

<b>Case Number:</b>	CM15-0064610		
<b>Date Assigned:</b>	04/10/2015	<b>Date of Injury:</b>	12/10/2013
<b>Decision Date:</b>	05/12/2015	<b>UR Denial Date:</b>	03/26/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/06/2015

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker was a 53 year old male, who sustained an industrial injury, December 10, 2013. The injury was sustained by falling off a horse at work. The injured worker received the following treatments in the past right shoulder MRI, right shoulder X-ray, Tylenol, Advil and home exercise program. The injured worker was diagnosed with right shoulder impingement syndrome, full thickness tear of the subscapularis tendon. According to progress note of December 11, 2014, the injured workers chief complaint was right shoulder pain. The injured worker's pain was mild to moderate in intensity radiating to the right side of the neck. The injured worker was complaining of stiffness, tightness, grinding, popping and cracking in the right shoulder. The injured worker stated after keeping the right shoulder elevated for an extended period of time, it was painful to lower. The right shoulder symptoms were aggravated by lifting, carrying, pushing or pulling more than 20 pounds. The physical exam noted obvious deformity with grade 3 separation of the AC joint on the right. There was no tenderness with palpation to the shoulders. The treatment plan included cold therapy unit, CPM (continuous range of motion machine) and electrical stimulator (TENS (transcutaneous electrical nerve stimulator) unit).

### IMR ISSUES, DECISIONS AND RATIONALES

The Final Determination was based on decisions for the disputed items/services set forth below:

**Cold therapy unit:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Continuous Flow Cryotherapy.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Continuous-flow cryotherapy section.

**Decision rationale:** Regarding the request for Cold Therapy Unit, CA MTUS does not address the issue. ODG cites that continuous-flow cryotherapy is recommended as an option after surgery for up to 7 days, including home use, but not for non-surgical treatment. Within the documentation available for review, it is noted that the utilization reviewer certified the request for a 7-day rental. However, the current request is open-ended, which is not supported, and there is no provision for modification to allow for a 7-day rental as recommended by the guidelines. As such, the currently requested Cold Therapy Unit is not medically necessary.

**CPM:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Continuous Flow Cryotherapy.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation X Official Disability Guidelines (ODG) Shoulder, Continuous passive motion (CPM).

**Decision rationale:** Regarding the request for continuous passive motion machine, California MTUS and ACOEM do not contain criteria for this treatment modality. ODG states continuous passive motion is not recommended after shoulder surgery or for nonsurgical treatment. As such, the currently requested continuous passive motion machine is not medically necessary.

**Electrical stimulator:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of TENS; Interferential Current Stimulation (ICS); Neuromuscular electrical stimulation (NMES device).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 114-117 of 127.

**Decision rationale:** Regarding the electrical stimulator, CA MTUS does support the use of TENS for 30 days after surgery. Within the medical information available for review, the utilization reviewer did modify the generic request for an electrical stimulator to TENS for 30 days. However, unfortunately, there is no provision for modification of the current request. In light of the above issues, the electrical stimulator is not medically necessary.

