

<b>Case Number:</b>	CM15-0066308		
<b>Date Assigned:</b>	04/14/2015	<b>Date of Injury:</b>	03/13/2013
<b>Decision Date:</b>	05/14/2015	<b>UR Denial Date:</b>	03/23/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/07/2015

### 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: Illinois, California, Texas  
 Certification(s)/Specialty: Orthopedic Surgery

### 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 is a 29-yo male who sustained an industrial injury on 3/13/13. Injury occurred when he tried to prevent a medication cart from falling over and injured his left shoulder. Past medical history was positive for respiratory problems and stroke. The 9/11/13 left shoulder MRI impression documented findings compatible with a focal anterior distal supraspinatus tendon full thickness tear and mild left acromioclavicular (AC) joint arthropathy with mild curvilinear trabecular stress response of the distal left clavicle. The 3/9/15 treating physician report cited persistent left shoulder pain despite all attempts at aggressive conservative treatment. Physical exam documented left shoulder flexion 160 degrees, abduction 140 degrees, external rotation 60 degrees and internal rotation 50 degrees. There was left supraspinatus and biceps tenderness, and 4/5 flexion and external rotation weakness. AC compression, impingement, and O'Brien's tests were positive on the left. MRI showed full thickness supraspinatus tear with subacromial impingement and AC joint degenerative joint disease. Treatment plan included request for authorization for left shoulder arthroscopy, assistant surgeon, pre-operative medical clearance, post-operative sling and physical therapy. The 3/23/15 utilization review certified the request for left shoulder arthroscopy, possible arthroscopic versus open decompression with acromioplasty, rotator cuff debridement versus repair, resection of coracoacromial ligament and/or bursa, and distal clavicle resection. The associated request for post-operative cold therapy unit purchase was modified to allow for a 7-day rental of a standard cold therapy unit consistent with the Official Disability Guidelines. The associated request for post-operative electrical stimulation was non-certified as there is no evidence that post-operative

pain levels will not be well controlled with medications. The associated request for post-operative CPM for the left shoulder was non-certified as there was no guidelines support and it was not indicated for the injured worker's condition.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Postoperative cold therapy unit-purchase for the left shoulder: 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), Shoulder Chapter, 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: Continuous flow cryotherapy.

**Decision rationale:** The California MTUS are silent regarding cold therapy devices. The Official Disability Guidelines recommend continuous flow cryotherapy as an option after shoulder surgery for up to 7 days, including home use. The 3/23/15 utilization review modified the request for post-operative cold therapy unit purchase to allow for a 7-day rental of a standard cold therapy unit. There is no compelling reason presented to support the medical necessity of continuous flow cryotherapy in excess of guideline recommendations and beyond the current certification. Therefore, this request is not medically necessary.

#### **Postoperative E-stimulation for the left shoulder: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS, post-operative pain (transcutaneous electrical nerve stimulation) Page(s): 116-117.

**Decision rationale:** The California MTUS guidelines recommend transcutaneous electrotherapy with a TENS unit as a treatment option for acute post-operative pain in the first 30 days after surgery. TENS appears to be most effective for mild to moderate thoracotomy pain. It has been shown to be of lesser effect, or not at all for other orthopedic surgical procedures. Guidelines state that the proposed necessity of the electrotherapy unit should be documented. Guidelines have not been met. The patient was scheduled for shoulder arthroscopic surgery. There is no indication that standard post-op pain management would be insufficient. There is no documentation that the patient was intolerant or unresponsive to pain medications during the pre-operative period. There is no clear documentation of the type of electrotherapy requested to allow for guideline application relative to specific use. Therefore, this request is not medically necessary.

#### **Postoperative CPM unit for the left shoulder: 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), Shoulder Chapter CPM Section.

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

**Decision rationale:** The California MTUS are silent regarding continuous passive motion (CPM) units. The Official Disability Guidelines do not recommend CPM units for rotator cuff problems. These units are recommended as an option for adhesive capsulitis, up to 4 weeks/5 days per week. Guideline criteria have not been met. Arthroscopic rotator cuff repair was requested. There is no clinical evidence suggestive of adhesive capsulitis. There is no compelling reason to support the medical necessity of this unit in the absence of guideline support. Therefore, this request is not medically necessary.