

<b>Case Number:</b>	CM15-0095574		
<b>Date Assigned:</b>	05/22/2015	<b>Date of Injury:</b>	04/01/2013
<b>Decision Date:</b>	06/26/2015	<b>UR Denial Date:</b>	04/22/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/18/2015

### 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 is a 57 year old female with an industrial injury dated 4/01/2013. The injured worker's diagnoses include biceps tenosynovitis, 50% partial thickness rotator cuff tear, chronic subacromial impingement, acromioclavicular joint (AC) degenerative joint disease, status post industrial left shoulder injury and adhesive capsulitis of left shoulder. Treatment consisted of ultrasound study of the left shoulder dated 3/26/2014, prescribed medications, and periodic follow up visits. In a progress note dated 3/9/2015, the treating physician noted the failure of aggressive conservative measures. The injured worker rated pain 7-8/10. Objective findings revealed decrease left shoulder range of motion with tenderness in the supraspinatus, great tuberosity ,bicep tendons and acromioclavicular joint (AC) , decrease left shoulder muscle strength and positive proactive tests on the left. The treatment plan included left shoulder surgery and associated surgical services. The treating physician prescribed services for Home Continuous Passive Motion device for 45 days, Surgistim unit for 90 days and Coolcare cold therapy unit now under review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Home Continuous Passive Motion device for 45 days: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder chapter, Continuous Passive Motion.

**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.

**Surgistim unit for 90 days:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Galvanic Stimulation; Interferential Current Stimulation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines x 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 114-121 of 127.

**Decision rationale:** Regarding the request for Surgistim unit, this unit is a combination electrical stimulation unit which includes interferential current stimulation, high-volt pulsed current/galvanic stimulation, neuromuscular stimulation, and pulsed direct current stimulation. In order for a combination device to be supported, there needs to be guideline support for all incorporated modalities. Chronic Pain Medical Treatment Guidelines state that interferential current stimulation is supported postoperative only when significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment. Galvanic/high-volt pulsed current stimulation and neuromuscular stimulation are both not supported for postoperative use. Within the documentation available for review, none of the criteria outlined above have been met and there is no clear rationale for the use of this device despite the recommendations against its use by the guidelines. As such, the currently requested Surgistim is not medically necessary.

**Coolcare 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, Shoulder, 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 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, the device was recommended certified x 7 days by utilization review. The guidelines do not support use beyond 7 days or purchase of the device and, unfortunately, there is no provision for modification of the current request. As such, the currently requested Cold Therapy Unit is not medically necessary.