

<b>Case Number:</b>	CM14-0206358		
<b>Date Assigned:</b>	12/18/2014	<b>Date of Injury:</b>	04/20/2009
<b>Decision Date:</b>	10/20/2015	<b>UR Denial Date:</b>	11/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/09/2014

### 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: Preventive Medicine, Occupational Medicine

### 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 (IW) is a 64-year-old female who sustained an industrial injury on 04-20-2009. The mechanism of the injury is not found in the records reviewed. The injured worker was diagnosed as having: Displacement of cervical intervertebral disc without myelopathy. Bilateral shoulder impingement. Displacement of lumbar intervertebral disc without myelopathy, and status post left carpal tunnel release and left DeQuervain's release. Treatment to date has included left carpal tunnel release and left DeQuervain's release 06-27-2014, physical therapy and medications. On 09/29/2014, the injured worker complained of right shoulder pain. Inspection of the shoulders revealed no surgical incisions, deformity, scarring, atrophy, scapular winging, or scapular dyskinesis. There is tenderness on the right deltoid. Range of motion on the right was flexion of 100 (out of possible 180) degrees, extension 30 (out of possible 50 degrees), abduction 150 (of possible 180) degrees, adduction 40 (out of possible 50 degrees), internal rotation 70 (of possible 90 degrees) and external rotation 70 (of possible 90 degrees). The left shoulder had flexion of 120 (out of possible 180) degrees, extension 30 (out of possible 50 degrees), abduction 150 (of possible 180) degrees, adduction 30 (out of possible 50 degrees), internal rotation 50 (of possible 90 degrees) and external rotation 60 (of possible 90 degrees). There was impingement on the right shoulder. The treatment plan of care was for physical therapy of the lumbar and cervical spine, and right shoulder arthroscopy with rotator cuff repair. In conjunction with the surgery request, the physician also requested authorization for a cold therapy unit, a sling with abduction pillow, a shoulder exercise kit, and a continuous passive movement unit. A request for authorization was submitted for: 1. Tech Cold Therapy System

Rental # days 7. 2. Q Tech Purchase: non-segmental pneumatic appliance for the use with pneumatic compressor, half arm. 3. Shoulder CPM Rental # Days. 4. CPM Soft Good.

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

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

#### **Tech Cold Therapy System Rental # days 7: 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) 11th Edition Shoulder Section, 2013, 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 (Acute & Chronic), Continuous-flow cryotherapy.

**Decision rationale:** The Official Disability Guidelines recommend continuous-flow cryotherapy as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. However, the effect on more frequently treated acute injuries (eg, muscle strains and contusions) has not been fully evaluated. The available scientific literature is insufficient to document that the use of continuous-flow cooling systems (versus ice packs) is associated with a benefit beyond convenience and patient compliance. The original request was rental for 21 days. The first reviewer modified the request to 7 days. Tech Cold Therapy System Rental # days 7 is not medically necessary.

#### **Q Tech Purchase: Non segmental pneumatic appliance for the use with pneumatic compressor, half arm: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Compression Device, Shoulder (Acute & Chronic).

**Decision rationale:** The Official Disability Guidelines do not generally recommend compression devices for the shoulder. The clinical information submitted for review fails to meet the evidence-based guidelines for the requested service. At present, based on the records provided, and the evidence-based guideline review, the request is non-certified. Q Tech Purchase: Non-segmental pneumatic appliance for the use with pneumatic compressor, half arm is not medically necessary.

### **Shoulder CPM Rental # 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 (ODG) 12th Edition, Shoulder, 2014, Continuous Passive Motion (CPM).

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

**Decision rationale:** The Official Disability Guidelines do not recommend CPM machines for shoulder rotator cuff problems. They are also not recommended after shoulder surgery or for nonsurgical treatment. An AHRQ Comparative Effectiveness Review concluded that evidence on the comparative effectiveness and the harms of various operative and nonoperative treatments for rotator cuff tears is limited and inconclusive. With regard to adding continuous passive motion to postoperative physical therapy, 11 trials yielded moderate evidence for no difference in function or pain, and one study found no difference in range of motion or strength. Shoulder CPM Rental # Days is not medically necessary.

### **CPM Soft Good: 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), 12th Edition, Shoulder, 2014, Continuous Passive Motion (CPM).

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

**Decision rationale:** The Official Disability Guidelines do not recommend CPM machines for shoulder rotator cuff problems. They are also not recommended after shoulder surgery or for nonsurgical treatment. An AHRQ Comparative Effectiveness Review concluded that evidence on the comparative effectiveness and the harms of various operative and nonoperative treatments for rotator cuff tears is limited and inconclusive. With regard to adding continuous passive motion to postoperative physical therapy, 11 trials yielded moderate evidence for no difference in function or pain, and one study found no difference in range of motion or strength. The request for rental of a CPM unit has been denied. CPM soft good is therefore not medically necessary.