

<b>Case Number:</b>	CM13-0044496		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	02/02/2011
<b>Decision Date:</b>	02/25/2014	<b>UR Denial Date:</b>	10/24/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/29/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery, has a subspecialty in Spine Surgery and is licensed to practice in Texas. He 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 physician reviewer was selected based on his clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/services. He is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 patient is a 60-year-old male who reported an injury on 02/01/2011 after a wrenching pipe struck his shoulder. The shoulder injury ultimately resulted in right shoulder arthroscopy. The patient's most recent clinical examination findings included postsurgical right shoulder soreness and achiness. The patient's diagnoses included status post right shoulder arthroscopy x2. The patient's treatment plan included continued use of a continuous passive motion machine and continuation of medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Pro Tech Multi stimulation unit for 30 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, and California Medical Treatment Utilization Schedule: Post-Surgical Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines. Page(s): 114 and 118.

**Decision rationale:** : The requested Pro Tech multi-stimulating unit for 30 days is not medically necessary or appropriate. The requested unit provides 3 modalities of treatment: a TENS, interferential, and neuromuscular stimulation. California Medical Treatment Utilization

Schedule does recommend the use of a TENS unit to assist with management of acute postoperative pain. Additionally, California Medical Treatment Utilization Schedule does support the use of interferential units to assist with controlling postoperative pain to allow for participation in a physical therapy program. However, neuromuscular electrical stimulation is not supported by guideline recommendations as it is primarily used in the rehabilitation of stroke patients. As the combination unit contains therapy that is not supported by guideline recommendations, the use of this unit would not be supported. As such, the requested Pro Tech multi-stimulation unit for 30 days is not medically necessary or appropriate.

**CPM:** 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, and California Medical Treatment Utilization Schedule: Post-Surgical Treatment Guidelines.

**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 passive motion (CPM).

**Decision rationale:** : The requested continuous passive motion machine is not medically necessary or appropriate. Official Disability Guidelines do not recommend the use of a continuous passive motion machine for the treatment of rotator cuff issues postsurgically or presurgically. Therefore, the use of this type of intervention would not be supported. As such, the requested continuous passive motion machine is not medically necessary or appropriate.

**Cold Therapy Unit 14 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, and California Medical Treatment Utilization Schedule: Post-Surgical Treatment Guidelines.

**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.

**Decision rationale:** The requested cold therapy unit for 14 days is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient underwent surgical intervention of the shoulder. Official Disability Guidelines recommend the use of a cold therapy unit for up to 7 days for the postsurgical management of a patient. The request for 14 days exceeds this recommendation. There are not exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations.

**Q Tech multi stim unit 30 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, and California Medical Treatment Utilization Schedule: Post-Surgical Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines. Page(s): 117, 118, 121.

**Decision rationale:** : The requested OrthoStim4 unit is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient underwent surgical intervention. The requested equipment is a 4 module stimulator that contains an interferential current, galvanic pulsed current, neuromuscular stimulation, and direct pulsed current. California Medical Treatment Utilization Schedule does recommend the use of interferential current stimulation in the postsurgical management of the patient. However, California Medical Treatment Utilization Schedule does not recommend the use of neuromuscular electrical stimulation devices or galvanic stimulation as the OrthoStim4 unit is a compounded device that consists of stimulators that are not recommended California Medical Treatment Utilization Schedule, this device would not be indicated. As such, the requested OrthoStim4 unit would not be medically necessary or appropriate.