

<b>Case Number:</b>	CM14-0117718		
<b>Date Assigned:</b>	08/06/2014	<b>Date of Injury:</b>	06/26/2010
<b>Decision Date:</b>	09/17/2014	<b>UR Denial Date:</b>	07/03/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/25/2014

### 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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation, and Pain Medicine, and is licensed to practice in Texas and Ohio. 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/services. He/she 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 injured worker is a 48-year-old male who reported an injury on 06/26/2010 due to a fall at work. The injured worker was diagnosed with cervical disc displacement, brachial neuritis NOS, and lumbar disc displacement. The injured worker performed home exercises and was authorized for 8 sessions of postsurgical physical therapy to the right shoulder. No diagnostic testing was noted in these documents. On 06/14/2014, the injured worker underwent arthroscopic right shoulder sub-acromial decompression. On 08/01/2014, the injured worker reported constant right shoulder pain, noted at 6/10 on the pain scale. The pain radiated to the neck with numbness to both hands. The injured worker also reported constant lower back pain of 6/10, radiating to bilateral lower extremities, including numbness and tingling, greater to the left leg. The physician noted that left inguinal region pain radiated to the left testical. There was tenderness to the cervical spine, trapezius, and lumbar spine. There was a mild antalgic gait. The injured worker used a cane. The injured worker was prescribed Norco, Omeprazole, hypertension medications, Metformin, and cholesterol medications. The physician recommended an X-Force stimulator unit purchase, conductive garments 2, and Pro Sling with abduction pillow. The rationale is for postsurgical use to the right shoulder. A request for authorization form was signed on 06/16/2014 and made available for review.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**X-force Stimulator Unit purchase with 3 months of supplies: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 116.

**Decision rationale:** The request for an X-Force Stimulator Unit purchase with 3 months of supplies is not medically necessary. California MTUS Guidelines for a TENS Unit for postoperative pain recommends this as a treatment option for postoperative pain in the first 30 days post surgically. Transcutaneous Electrical Nerve Stimulation appears to be most effective for mild to moderate Thoracotomy pain with a lesser to no effect for other orthopedic surgical procedures. The proposed necessity of the unit should be documented upon request. Rental would be preferred over purchase during this 30 day period. CA MTUS guidelines recommends rental over purchase of a TENS unit. The physician did not document the need of a purchase. On 06/14/2014, the injured worker underwent Arthroscopic Right Shoulder Sub-Acromial Decompression. The physician recommended the injured worker use this treatment post-surgically. Guidelines support 30 day use of a TENS unit post-operatively and the injured worker is beyond the initial 30 days post-operatively. Also, the request as submitted is for 3 months use and this would exceed guideline recommendations. As such, the request is not medically necessary.

**Conductive Garments # 2:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** The request for conductive garments quantity 2 is non-certified. As the requested primary procedure is not supported by the documentation, the requested ancillary service is also not supported. As such, the request is non-certified.

**Pro-Sling with Abduction Pillow # 1:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment in Workers Compensation, Shoulder (Acute & Chronic).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Post-Operative Abduction Pillow Sling.

**Decision rationale:** The request for Pro Sling with Abduction Pillow 1 is not medically necessary. Official Disability Guidelines recommends a post-operative abduction pillow sling following an open repair of large and massive rotator cuff tears. The abduction pillow sling keeps the arm in a position that takes tension off the repaired tendon. Abduction pillows for

large and massive tears may decrease tendon contact to the repaired sulcus, but are not used for arthroscopic repairs. The injured worker underwent arthroscopic surgery which would not meet guideline indications for this device. As such, the request is not medically necessary.

**Q-Tech Cold Therapy Recovery System with wrap for 35 days:** 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 (ODG), Shoulder, Continuous-Flow Cryotherapy.

**Decision rationale:** The request for Q-Tech Cold Therapy Recovery System with wrap for 35 days is not medically necessary. Official Disability Guidelines recommend the use of Continuous-Flow Cryotherapy as an option after surgery and recommend the use of this device for up to 7 days. The current request is for a 35 day rental which exceeds guideline recommendations. Also, the injured worker underwent surgery in 06/2014 and the recommended time to utilize this device has elapsed. As such, the request is not medically necessary.