

<b>Case Number:</b>	CM14-0040516		
<b>Date Assigned:</b>	06/30/2014	<b>Date of Injury:</b>	06/20/2011
<b>Decision Date:</b>	08/21/2014	<b>UR Denial Date:</b>	03/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/07/2014

### 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 Family Medicine and is licensed to practice in California. 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 46 year old male who sustained a work injury on 6/20/11 involving the left arm and right shoulder. An MRI in 2012 showed distal supraspinatus tendonosis and glenohumeral joint effusion. He was diagnosed with right shoulder impingement syndrome and underwent subacromial decompression and arthroscopy in October 2013. Post-operatively he underwent physical therapy. The physician recommended the use of an X-force stimulator unit, a motion constant passive motion machine and a cold therapy recovery system for 3 months.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**X-force stimulator unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines transcutaneous electrical nerve stimulator.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS unit Page(s): 116.

**Decision rationale:** An X-force unit provides TENS functions. According to the MTUS guidelines, a TENS unit may be used for 30 days post-operatively. It is beneficial for thoracotomy pain and less beneficial for other orthopedic procedures. The length of time of X-

force use is presumed to be 3 months based on the amount of supplies requested. Therefore the amount of use exceeds the recommendations of the guidelines and is not medically necessary.

**3 months supplies for stimulator unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines transcutaneous electrical nerve stimulation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS unit Page(s): 116.

**Decision rationale:** Based on the lack of necessity of an X-force unit as outlined above, 3 months supplies for the unit is not medically necessary.

**2 conductive garmets:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines transcutaneous electrical nerve stimulation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS unit Page(s): 116.

**Decision rationale:** Based on the lack of necessity of an X-force unit as outlined above, conductive garments are not medically necessary.

**shoulder constant passive motion machine with pads:** 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 (acute on chronic).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Pain.

**Decision rationale:** According to the ACOEM guidelines, physical therapy is recommended for initial treatment and evaluation for home exercises. According to the ODG guidelines, Use of a home pulley system for stretching and strengthening should be recommended. The use of active treatment modalities instead of passive treatments is associated with substantially better clinical outcomes. There is limited evidence to support its use. In addition, the length of use is not specified in the clinical documents. The request therefore for a passive range of motion machine is not medically necessary.

**Q-tech cold therapy recovery system with wrap:** 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 (acute on chronic).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Pain.

**Decision rationale:** According to the ACOEM and MTUS guidelines, a Q-tech cold system is not specified. However, heat or cold applications are recommended a few days after the acute complaint. In this case, the length of time of use of the Q-tech is not specified. In addition, according to the ODG guidelines there is limited evidence or published studies to support its use therefore it is not medically necessary.