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| <b>Case Number:</b>   | CM14-0055358 |                              |            |
| <b>Date Assigned:</b> | 07/09/2014   | <b>Date of Injury:</b>       | 09/12/2013 |
| <b>Decision Date:</b> | 09/03/2014   | <b>UR Denial Date:</b>       | 04/18/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 04/24/2014 |

### 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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Texas. 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 45 year old male who sustained an injury on 09/12/13 while lifting a table. The injured worker went to twist the table back into position and felt immediate pain in the right shoulder. The injured worker is noted to have had a prior right shoulder surgery completed in 2013 and described residual decreased range of motion and pain. The injured worker was still being managed with narcotic medications as well as muscle relaxers. The injured worker did have a functional capacity evaluation completed on 03/12/14 which noted profound weakness in the right shoulder versus the left in all planes. The injured worker continued to complain of severe right shoulder pain on the orthopedic evaluation from 03/17/14. The injured worker's range of motion testing was deferred at this evaluation due to severe pain. A substantial amount of grip weakness was noted in the right hand versus the left. The injured worker was recommended for additional physical therapy at this evaluation as well as the use of a stimulator unit hot and cold unit purchase as well as a shoulder home exercise rehabilitation kit. This requested durable medical equipment was denied by utilization review on 04/18/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Multi Stim Unit Plus Supplies x5 Month Rental:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrostimulator Page(s): 113-117.

**Decision rationale:** In regards to the request for a multi stim unit plus supplies x 5 month rental, this reviewer would not have recommended this request as medically necessary. Although the injured worker did reasonably require further physical therapy for the right shoulder and as guidelines do consider the use of a stimulator unit as an option and adjunct to formal physical therapy, the current evidence based guidelines limit the use of electrical stimulators to a one month trial only. The requested 5 month rental would be considered excessive without evidence of an initial trial with success. Therefore, this reviewer would not have recommended this request as medically necessary.

**Heat/Cold Unit Purchase:** 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; Hubbard, 2004; Osbahr, 2002; Singh, 2001.

**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, Cold Compression Unit.

**Decision rationale:** In regards to the request for heat/cold unit purchase, this reviewer would not have recommended this request as medically necessary. Hot and cold therapy units can be utilized in the perioperative period for the shoulder following surgery; however, there is no evidence from the literature establishing the efficacy of hot and cold therapy units outside of the perioperative period for the shoulder. Guidelines limit the use of hot and cold therapy units for the shoulder to 7 day rental following surgery. There would be no indication for the use of this type of durable medical equipment outside of the perioperative period and the request would not be considered medically necessary.

**Shoulder Home Exercise Rehab Kit:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Exercise. Decision based on Non-MTUS Citation Bruce, 2005; State, 2002; Airaksinen, 2006; Smeets, 2006; Rooks, 2007; Burleson, 2008; Gusi, 2008; Little, 2008.

**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, Exercise.

**Decision rationale:** In regards to the request for a shoulder home exercise rehab kit, this reviewer would have recommended this request as medically necessary. The injured worker is noted to have profound weakness in the right shoulder on the most recent functional capacity evaluation with notable weakness in the right upper extremity on physical examination. Given

the extent of the right shoulder weakness noted on physical examination, the injured worker would reasonably benefit from a home exercise rehabilitation kit as an adjunct to formal physical therapy. Therefore, this request would have been considered standard of care and medically appropriate.