

<b>Case Number:</b>	CM14-0111602		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	05/26/2012
<b>Decision Date:</b>	01/05/2015	<b>UR Denial Date:</b>	06/27/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/17/2014

### 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 Management and is licensed to practice in Tennessee. 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:

This is a 55-year old female with a 5/26/12 injury date. In a 5/9/14 UR decision, a right shoulder arthroscopy with decompression and Mumford was approved. In a 4/30/14 note, the patient complained of constant pain and discomfort in the right shoulder, and mild relief with a recent cortisone injection and 12 weeks of physical therapy. Objective findings included right shoulder tenderness, forward flexion to 90 degrees, extension to 30 degrees, and positive impingement signs. The provider recommended right shoulder surgery and requested the following items for the post-op period: Pro-stim TENS unit, Q-tech head/cold compression, and CPM for the shoulder. Diagnostic impression: right shoulder impingement syndrome. Treatment to date: injection, physical therapy, medication. A UR decision on 6/27/14 denied the request for Q-tech Therapy Recovery System with wraps X 21 days because the guidelines and literature do not typically support devices that combine both temperature and pressure utilization. The request for shoulder CPM with pads X 30 days was denied because there is a lack of evidence that CPM for a post-op shoulder is effective with respect to pain and function. The request for Pro-Stim 5.0 X 3 month supply was denied because the device is unproven in the medical literature.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Q-Tech Therapy Recovery System w Wrap x21 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 Knee and Leg Chapter

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Knee Chapter-- Continuous-flow cryotherapy.

**Decision rationale:** CA MTUS does not address this issue. ODG states that continuous-flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. However, ODG states that while there are studies on continuous-flow cryotherapy, there are no published high quality studies on the Q-Tech device or any other combined system. There is no rationale identifying why a cryotherapy unit would be insufficient. In addition, only a 7-day rental is recommended by ODG. Therefore, the request for Q-Tech Therapy Recovery System w Wrap x21 days is not medically necessary.

**Shoulder CPM w Pads x30days:** 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

**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--CPM

**Decision rationale:** CA MTUS does not address this issue. ODG does not consistently support the use of CPM in the postoperative management of rotator cuff tears; but CPM treatment for adhesive capsulitis provides better response in pain reduction than conventional physical therapy. However, this patient suffers from impingement syndrome and there is no evidence of a diagnosis of adhesive capsulitis. Therefore, the request for shoulder CPM with pads x 30 days is not medically necessary.

**Pro-Stim 5.0 x3 month supply:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrical Nerve Stimulation, Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential current stimulation Page(s): 120.

**Decision rationale:** CA MTUS states that interferential current stimulation (ICS) is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain,

jaw pain, soft tissue shoulder pain, cervical neck pain and knee pain. While not recommended as an isolated intervention, ICS can be considered for the treatment of significant pain from postoperative conditions that limit the ability to perform exercise programs or physical therapy. Since the Pro-Stim unit is intended for post-op use after the patient's shoulder surgery, the device is recommended. Therefore, the request for Pro-Stim 5.0 x 3 month supply is medically necessary.