

<b>Case Number:</b>	CM15-0025665		
<b>Date Assigned:</b>	02/18/2015	<b>Date of Injury:</b>	03/28/2012
<b>Decision Date:</b>	04/07/2015	<b>UR Denial Date:</b>	02/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/10/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: California  
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 41 year old female injured worker suffered and industrial injury on 3/28/2012. The diagnoses were left shoulder pain with impingement. The diagnostic studies were magnetic resonance imaging of the left shoulder the treatments were medications and physical therapy, medications, acupuncture and aqua therapy. The treating provider reported residual symptoms to the neck and left upper extremity with pain in the shoulder, elbow and wrist. On exam of the left shoulder there is tenderness over the AC joint with restricted range of motion. The associated surgical procedure was noncertified and therefore the accompanying requests below were not applicable. The Utilization Review Determination on 2/10/2015 non-certified: 1. Multi Stim Unit Plus Supplies for 3 Months Rental, for the Left Shoulder. 2. CPM Machine for 6 Weeks Rental for the Left Shoulder. 3. Pain Pump for 4 Days Rental for the Left Shoulder, MTUS. 4. Ultra Sling for the Left Shoulder, ODG.

### 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 for 3 Months Rental, for the Left Shoulder: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 114-121.

**Decision rationale:** The 2/05/15 Utilization Review letter states the Multi-stim unit plus supplies for 3-months rental for the left shoulder, requested on the 1/31/15 medical report was denied because the multi-stim unit contains NMES which is not recommended by MTUS guidelines. The 1/31/15 medical report was not provided for this review. The 1/23/15 orthopedic report states the patient complains of left shoulder pain but was afraid to have surgery. She also has left elbow and wrist pain. The physician states the patient has had PT, acupuncture, medications, modified duty, and positive MRI, and cortisone injections were recommended but denied. He recommends surgical intervention for a rotator cuff tear. There was a request for a post-op Multi Stim unit. There was no discussion on the type of multi-stim unit, or what type of electrical stimulation the unit provides. MTUS Chronic Pain Medical Treatment Guidelines, for TENS, pg114-121, states TENS is an option for acute post-operative pain in the first 30-days post-surgery; but also states: The proposed necessity of the unit should be documented upon request. MTUS guidelines recommend against Galvanic Stimulation and NMES. MTUS allows for postsurgical use of interferential therapy but only if the physician has provided documentation or proven efficacy. There is not enough information provided to confirm that all the electrical stimulation components of the "Multi Stim" unit are in accordance with MTUS recommendations. The request for Multi-stim unit plus supplies for 3-months rental for the left shoulder IS NOT medically necessary.

**CPM Machine for 6 Weeks Rental for the Left Shoulder:** 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 Shoulder Chapter online, under Continuous passive motion (CPM).

**Decision rationale:** The 2/05/15 Utilization Review letter states the CPM machine for 6-weeks rental for the left shoulder requested on the 1/31/15 medical report was denied because the guidelines do not endorse CPM units for rotator cuff surgery. The 1/31/15 medical report was not provided for this review. The 1/23/15 orthopedic report states the patient complains of left shoulder pain but was afraid to have surgery. She also has left elbow and wrist pain. The physician states the patient has had PT, acupuncture, medications, modified duty, and positive MRI, and cortisone injections were recommended but denied. He recommends surgical intervention for a rotator cuff tear. Physical examination shows left shoulder flexion at 15 degs, abduction to 130 degrees, negative impingement. There was a request for a CPM machine for 6-weeks rental for the left shoulder. There was no rationale provided for the CPM unit. ODG-TWC guidelines, Shoulder Chapter online, under Continuous passive motion (CPM) states "Not recommended for shoulder rotator cuff problems, but recommended as an option for adhesive capsulitis, up to 4 weeks/5 days per week." The patient is not reported to have adhesive capsulitis, and the request for CPM use for 6-weeks exceeds the ODG recommendations of 4-

weeks. Based on the available records, the request for CPM machine for 6-weeks rental for the left shoulder, IS NOT medically necessary.

**Pain Pump for 4 Days Rental for the Left Shoulder: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS, post operative pain (transcutaneous electrical nerve stimulation).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines shoulder chapter online for: Postoperative pain pump.

**Decision rationale:** The 2/05/15 Utilization Review letter states the Pain pump for 4-days rental for the left shoulder requested on the 1/31/15 medical report was denied because guidelines do not recommend a postoperative pain pump. The 1/31/15 medical report was not provided for this review. The 1/23/15 orthopedic report states the patient complains of left shoulder pain but was afraid to have surgery. She also has left elbow and wrist pain. The physician states the patient has had PT, acupuncture, medications, modified duty, and positive MRI, and cortisone injections were recommended but denied. He recommends surgical intervention for a rotator cuff tear. The pain pump was requested, but there was no rationale provided. ODG guidelines, shoulder chapter online for: Postoperative pain pump, states: "Not recommended. Three recent moderate quality RCTs did not support the use of pain pumps. Before these studies, evidence supporting the use of ambulatory pain pumps existed primarily in the form of small case series and poorly designed, randomized, controlled studies with small populations. Much of the available evidence has involved assessing efficacy following orthopedic surgery, specifically, shoulder and knee procedures." The use of a pain pump for shoulder procedures is not in accordance with ODG guidelines. The request for Pain pump for 4-days rental for the left shoulder IS NOT medically necessary.

**Ultra Sling for the Left Shoulder: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment for Workers' Compensation, Online Edition Chapter: Shoulder.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204.

**Decision rationale:** The 2/05/15 Utilization Review letter states the Ultra Sling for the left shoulder requested on the 1/31/15 medical report was denied because the guidelines (ODG) states this was for open repair of the rotator cuff, and the patient had arthroscopic repair. The 1/31/15 medical report was not provided for this review. The 1/23/15 orthopedic report states the patient complains of left shoulder pain but was afraid to have surgery. She also has left elbow and wrist pain. The physician states the patient has had PT, acupuncture, medications, modified duty, and positive MRI, and cortisone injections were recommended but denied. He recommends surgical intervention for a rotator cuff tear. Ultra Sling for the left shoulder was requested, but

there was no rationale provided. Utilization review denied the sling based on ODG guidelines. MTUS/ACOEM guidelines, chapter 9 discusses slings and provides support. MTUS guidelines supersedes ODG guidelines. MTUS/ACOEM, chapter 9, page 204, table 9-3, Recommendations under Options for Rotator Cuff tear: "Sling for acute pain" or for AC joint strain "Sling for comfort". The request for the sling is in accordance with MTUS/ACOEM guidelines, but not in accordance with ODG guidelines. MTUS guidelines trump ODG guidelines. The request for the Ultra Sling for the left shoulder IS medically necessary.