

<b>Case Number:</b>	CM15-0047654		
<b>Date Assigned:</b>	03/19/2015	<b>Date of Injury:</b>	09/20/2011
<b>Decision Date:</b>	05/01/2015	<b>UR Denial Date:</b>	02/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/13/2015

### 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: Texas, New York, California  
 Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

### 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 applicant is a represented 44-year-old who has filed a claim for chronic neck, shoulder, and low back pain reportedly associated with an industrial injury of December 20, 2011. In a Utilization Review report dated March 28, 2014, the claims administrator failed to approve a request for a multi-stimulator device with associated supplies, a continuous passive motion device, a sling, and a continuous cooling system apparently dispensed around March 20, 2014. The claims administrator stated that the aqua relief system was partially approved as a seven-day rental of the same. The applicant's attorney subsequently appealed. In an RFA form dated February 4, 2014, a multi-stimulator unit five month rental, continuous passive motion six week rental, electrodes, and aqua relief system were endorsed. Little-to-no narrative commentary accompanied the RFA form. The device rental suggested that these requests represented postoperative requests.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retro Multi-Stim Unit plus Supplies 5 Months Rental (DOS 3/20/14): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS, post operative pain (transcutaneous electrical nerve stimulation) Page(s): 116.

**Decision rationale:** No, the multi-stimulator unit plus five-month rental was not medically necessary, medically appropriate, or indicated here. While page 116 of the MTUS Chronic Pain Medical Treatment Guidelines does recommend usage of TENS unit as a treatment option for acute postoperative pain during the first 30 days postoperatively, here, however, the request represented a request for five months of postoperative/perioperative usage. Such treatment represented treatment well in excess of MTUS parameters. Little-to-no narrative commentary or applicant-specific rationale accompanied the February 4, 2014 RFA form so as to augment the request at hand. Therefore, the request was not medically necessary.

**Retro Shoulder CPM (DOS 3/20/14): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM V.3 > Shoulder > Specific Disorders > Adhesive Capsulitis > Education, Exercise, and Therapy Recommendation: Continuous Passive Motion for Treatment of Adhesive Capsulitis Continuous passive motion (CPM) is recommended in conjunction with a home exercise program for treatment of adhesive capsulitis. Indications - All adhesive capsulitis patients, especially moderate to severely affected patients. (1526).

**Decision rationale:** Similarly, the request for a shoulder continuous passive motion device was not medically necessary, medically appropriate, or indicated here. The MTUS does not address the topic of continuous passive motion devices. While the Third Edition ACOEM Guidelines does support usage of continuous passive motion for applicants who carry a diagnosis of shoulder adhesive capsulitis, in this case, however, as with the preceding request, the February 4, 2014 RFA form contained little-to-no narrative commentary or applicant-specific rationale so as to augment the request at hand. It was not explicitly stated or suggested that the applicant in fact carried a diagnosis of adhesive capsulitis for which the CPM device would have been indicated. Therefore, the request was not medically necessary.

**Retro Ultrasling (DOS 3/20/14): Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Integrated Treatment/ Disability Duration Guidelines Shoulder Disorders Post-operative abduction pillow sling.

**Decision rationale:** The request for an UltraSling was likewise not medically necessary, medically appropriate, or indicated here. The nature of the request was not detailed. However, the request appears to represent a request for a postoperative abduction pillow sling. The MTUS does not address the topic of postoperative abduction pillow slings. While ODG's Shoulder Chapter postoperative abduction pillow sling's topic does recommend usage of postoperative abduction pillow slings in applicants who undergo open, large, and/or massive rotator cuff repair surgeries, in this case, however, there was no mention of the applicant's undergoing an open, large, and/or massive rotator cuff repair surgery. Therefore, the request was not medically necessary.

**Retro Aqua Relief System (DOS 3/20/14): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Integrated Treatment/ Disability Duration Guidelines Shoulder Disorders Continuous-flow cryotherapy.

**Decision rationale:** Similarly, the request for an aqua relief system [purchase] was likewise not medically necessary, medically appropriate, or indicated here. The request in question seemingly represents a request for continuous flow cryotherapy device. The MTUS does not address the topic. While ODG's Shoulder Chapter continuous flow cryotherapy topic does recommend continuous flow cryotherapy for up to 7 days postoperatively, here, however, the requesting provider seemingly sought authorization to purchase the device in question. The request, thus, in effect, represented treatment in excess of ODG parameters. No rationale for the same was attached to the February 4, 2014 RFA form. Therefore, the request was not medically necessary.