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| <b>Case Number:</b>   | CM14-0163529 |                              |            |
| <b>Date Assigned:</b> | 10/17/2014   | <b>Date of Injury:</b>       | 05/26/2009 |
| <b>Decision Date:</b> | 12/02/2014   | <b>UR Denial Date:</b>       | 10/01/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 10/06/2014 |

### 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 Physical Medicine & Rehabilitation, has a subspecialty in Interventional Spine 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 patient is a 58 year old female with an injury date of 05/26/09. Based on the 05/09/13 progress report, the patient complains of right shoulder pain which she rates as a 4/10. "The patient reports that overall their condition has improved by 40% since the onset of the pain." The 07/18/13 report states that the patient's pain radiates from her arm down to her hand. She describes this pain as being throbbing and rates it as a 7/10. The patient has tenderness in her right shoulder and her right distal forearm. On 05/02/13, the patient had an arthroscopic subacromial decompression, partial anterior acromionectomy, and an insertion/placement of a pain pump catheter in the subacromial space of the right shoulder. On 09/05/13, the patient had a right radial tunnel decompression. The patient's diagnoses include right radial tunnel syndrome and right internal shoulder derangement. The utilization review determination being challenged is dated 10/01/14. Treatment reports were provided from 04/24/13, 05/09/13, and 07/18/13.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Retrospective motorized cold therapy unit purchase (Date of service: 5/2/13): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation Official Disability Guidelines - TWC Shoulder Procedure Summary (last updated 8/27/14)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Carpal tunnel syndrome chapter, Continuous cold therapy (CCT)

**Decision rationale:** According to the 07/18/13 report, the patient presents with right shoulder pain and pain which radiates from her arm down to her hand. . The report with the request was not provided. In regard to cold therapy, ODG guidelines recommend cold therapy "as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use." On 05/02/13, the patient had an arthroscopic subacromial decompression, partial anterior acromionectomy, and an insertion/placement of a pain pump catheter in the subacromial space of the right shoulder. The patient may use the cold therapy unit for up to 7 days; there is no discussion provided as to how long the patient intends on using this unit for. Recommendation is for denial.

**Retrospective On-Q pain pump purchase (Date of service: 5/2/13):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - TWC Shoulder Procedure Summary (last updated 8/27/14)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) postoperative pain pump under the shoulder chapter

**Decision rationale:** According to the 07/18/13 report, the patient presents with right shoulder pain and pain which radiates from her arm down to her hand. The report with the request was not provided. MTUS and ACOEM guidelines do not address On-Q pain pumps. ODG guidelines on postoperative pain pump under the shoulder chapter states the following: "Not recommended. Three recent moderate quality RCTs did not support the use of pain pumps... Three recent RCTs did not support the use of these pain pumps. This study neither supports nor refutes the use of infusion pumps. (Banerjee, 2008) This study concluded that infusion pumps did not significantly reduce pain levels. This study found no difference between interscalene block versus continuous subacromial infusion of a local anesthetic with regard to efficacy, complication rate, or cost." Due to lack of support from ODG guidelines, recommendation is for denial. Due to lack of support from ODG guidelines, recommendation is for denial.

**Retrospective American Imex-sterile electrodes (2) -- purchase (Date of service: 5/2/13):** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines interferential current stimulation Page(s): 118 -120.

**Decision rationale:** According to the 07/18/13 report, the patient presents with right shoulder pain and pain which radiates from her arm down to her hand. The report with the request was not provided. MTUS Guidelines pages 118 to 120 indicate that interferential current stimulation is not recommended as an isolated intervention. It is indicated for patient's not tolerating oral medications, post-op pain for example. If indicated, however, MTUS recommends trying the unit for 1 month before a home unit is provided. In this case, there is no indication that the patient has had a 1-month trial of the stimulator. Since the request for the IF stimulator unit was denied, the request of American Imex Sterile electrodes is also denial.

**Retrospective interferential unit purchase (Date of service: 5/2/13):** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines interferential current stimulation Page(s): 118-120.

**Decision rationale:** According to the 07/18/13 report, the patient presents with right shoulder pain and pain which radiates from her arm down to her hand. The report with the request was not provided. MTUS Guidelines page 118 to 120 indicates that interferential current stimulation is not recommended as an isolated intervention. If indicated, however, MTUS recommends trying the unit for one-month before a home unit is provided. There is no indication that the patient has had a one-month trial of the IF stimulator. Given that the request is for IF unit without a specific request for one-month trial, recommendation is for denial.

**Retrospective hand/wrist and elbow exercise kit purchase (Date of service: 9/5/13):** Overturned

**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 Official Disability Guidelines (ODG) shoulder chapter under exercise kit

**Decision rationale:** According to the 07/18/13 report, the patient presents with right shoulder pain and pain which radiates from her arm down to her hand. The report with the request was not provided. Exercise is recommended in MTUS, ACOEM, and ODG guidelines. ODG also support "exercise kit" under shoulder chapter. Although the "exercise kit" is not delineated, given the strong support for exercise in general, and a specific recommendation for exercise kit found under shoulder chapter, the current request appears reasonable. The patient does present with shoulder pain as well. Recommendation is for authorization.

**Retrospective pad for water circulating heat/cold unit purchase (Date of service: 9/5/13):** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007), Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 227, 265. Decision based on Non-MTUS Citation Official Disability Guidelines - TWC Elbow Procedure Summary (last updated 5/15/14)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Carpal tunnel syndrome chapter, Continuous cold therapy (CCT)

**Decision rationale:** According to the 07/18/13 report, the patient presents with right shoulder pain and pain which radiates from her arm down to her hand. The report with the request was not provided. In regard to cold therapy, ODG guidelines recommend cold therapy "as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use." There is no indication of how long the patient will be using this unit for. Since the request for a cold therapy unit is denied, the request for the pad/wrap is also denied.

**Retrospective American Imex sterile electrodes purchase (Date of service: 9/5/13):** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines interferential current stimulation Page(s): 118-120.

**Decision rationale:** According to the 07/18/13 report, the patient presents with right shoulder pain and pain which radiates from her arm down to her hand. The report with the request was not provided. MTUS Guidelines pages 118 to 120 indicate that interferential current stimulation is not recommended as an isolated intervention. It is indicated for patient's not tolerating oral medications, post-op pain for example. If indicated, however, MTUS recommends trying the unit for 1 month before a home unit is provided. In this case, there is no indication that the patient has had a 1-month trial of the stimulator. Since the request for the IF stimulator unit was denied, the request of American Imex Sterile electrodes is also denial.