

<b>Case Number:</b>	CM15-0027710		
<b>Date Assigned:</b>	02/20/2015	<b>Date of Injury:</b>	10/08/2012
<b>Decision Date:</b>	04/02/2015	<b>UR Denial Date:</b>	01/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/13/2015

### 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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 female injured worker who sustained an industrial injury on October 8, 2012. The mechanism of injury is unknown. The diagnoses have included impingement syndrome of the left shoulder and biceps tendon tendinitis. Treatment to date has included diagnostic studies, right shoulder surgery, physical therapy, injections and medication. Currently, the injured worker complains of worsening pain to her bilateral shoulders with certain activities. The pain was rated as a 9 on a 1-10 pain scale. She reports whole arm pain, a popping pain when moving the left shoulder and cramping numbness to the right shoulder. She describes her pain as severe and intermittent. Regarding the left shoulder, she has a positive Neer and Hawkin's sign. On January 20, 2015 Utilization Review non-certified left shoulder sling purchase, cold therapy unit for left shoulder purchase, pain pump for left shoulder purchase and IF unit left shoulder one month rental, noting the CA MTUS Guidelines. On February 13, 2015, the injured worker submitted an application for Independent Medical Review for review of left shoulder sling purchase, cold therapy unit for left shoulder purchase, pain pump for left shoulder purchase and IF unit left shoulder one month rental.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left shoulder sling for purchase: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 213. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Postoperative abduction pillow sling.

**Decision rationale:** Regarding the request for Sling/Abduction pillow for the shoulder, California MTUS addresses this issue via the ACOEM Guidelines Chapter 9. ACOEM Chapter 9 on page 213 in Table 9-6 states the following regard shoulder immobilizers: "Recommended:-- Brief use of a sling for severe shoulder pain (1 to 2 days), with pendulum exercises to prevent stiffness in cases of rotator cuff conditions (D)--Three weeks use, or less, of a sling after an initial shoulder dislocation and reduction (C)Not Recommended: Prolonged use of a sling only for symptom control (D)." ODG cites that postoperative abduction pillow slings are recommended as an option following open repair of large and massive rotator cuff tears, but not for arthroscopic repairs. Within the documentation available for review, there is documentation of intent to proceed with a left shoulder arthroscopy as documented in a note from January 2015. Per ACOEM, a sling/abduction pillow rental may be appropriate for brief usage for rotator cuff symptoms. And per ODG, this type of surgery altogether does not warrant a sling. Therefore, the request for purchase of a Shoulder Sling/Abduction pillow shoulder is not medically necessary.

**Pain pump for left shoulder for 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.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Section 9792.21(c), page 2 of Title 8, California Code of Regulations.

**Decision rationale:** In the case of this request, the California Medical Treatment Utilization Schedule does not contain specific guidelines on this particular request. Therefore, national evidence based guidelines are cited. It is further noted that the Official Disability Guidelines and ACOEM do not have provisions for this request either. In fact, there is a paucity of literature to support this item. Pain pumps are not considered standard of care following orthopedic surgeries, and do not have any evidence of improved outcomes versus standard pain management. Therefore, this request is not medically necessary.

**IF Unit for the left shoulder 1 month rental:** Upheld

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

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

**Decision rationale:** Regarding the request for interferential unit, CA MTUS Chronic Pain Medical Treatment Guidelines state that interferential current stimulation is not recommended as an isolated intervention. They go on to state that patient selection criteria if interferential stimulation is to be used anyways include pain is ineffectively controlled due to diminished effectiveness of medication, side effects or history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercises, or unresponsive to conservative treatment. If those criteria are met, then in one month trial may be appropriate to study the effects and benefits. With identification of objective functional improvement, additional interferential unit use may be supported. Within the documentation available for review, there is no indication that the patient has met the selection criteria for interferential stimulation (pain is ineffectively controlled due to diminished effectiveness of medication, side effects or history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercises, or unresponsive to conservative treatment.). In fact, this is a request for post-operative use in advance of knowing whether there will be significant limitations in progressing in a rehabilitation program. In light of the above issues, the currently requested interferential unit is not medically necessary.

**Cold therapy unit purchase for the left shoulder:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability 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, Continuous-flow cryotherapy section.

**Decision rationale:** Regarding the request for Cold Therapy Unit for use after surgery of the shoulder, the CA MTUS and ACOEM do not directly address this issue. While these guidelines recommend cold/heat application, they do not have details of cold/heat units. ODG cites that continuous-flow cryotherapy is recommended as an option after surgery for up to 7 days, including home use, but not for non-surgical treatment. Within the documentation available for review, the request is for a purchase, which is in excess of guidelines which specify for a rental of 7 days only. As such, the current request is not medically necessary.