

<b>Case Number:</b>	CM15-0043035		
<b>Date Assigned:</b>	03/13/2015	<b>Date of Injury:</b>	04/29/2009
<b>Decision Date:</b>	04/22/2015	<b>UR Denial Date:</b>	03/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/06/2015

### 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, Florida

Certification(s)/Specialty: Anesthesiology, 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:

The injured worker (IW) is a 62 year old male, who sustained an industrial injury on 04/29/2009. He reported pain in the right shoulder and right knee. The injured worker was diagnosed as having right glenohumeral joint osteoarthritis and arthrofibrosis. Treatment to date has included arthroscopic surgery 08/08/2014 a home exercise program, nonsteroidal anti-inflammatory and right glenohumeral joint corticosteroid injections. There was documentation of significant pain relief after repeated steroid injections and PT. Currently, the injured worker complains of pain in the right shoulder. Treatment plans include conservative treatment of home exercise strengthening and ice with formal physical therapy, medications and purchase of a Spinal Q vest and purchase of a posture shirt. A Utilization Review determination was rendered recommending non certification Spinal Q Vest and Posture shirt.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Spinal Q Vest:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), criteria for DME.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chronic Pain Treatment Guidelines 9792.21. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Shoulder Durable Medical Equipments.

**Decision rationale:** The CA MTUS did not address the use of Durable Medical Equipment (DME) or devices such as Alignment Vests. The ODG guidelines recommend that DME or devices can be utilized if the use is necessary for accomplishment of mobilization. The records indicate that the patient reported pain relief and improvement in function following treatments with medications, shoulder steroid injections and physical therapy. There is no documentation of severe limitation of range of motion or function of the shoulders. There is lack of guidelines and peer review data supporting the use of Spinal Q Vest in the treatment of chronic shoulder arthritis pain. The criteria for the purchase of Spinal Q Vest was not met. The request is not medically necessary.

**Posture shirt:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), criteria for DME.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chronic Pain Treatment Guidelines 9792.21. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Shoulder DME.

**Decision rationale:** The CA MTUS did not address the use of Durable Medical Equipment (DME) or devices such as Posture Shirt. The ODG guidelines recommend that DME or devices can be utilized if the use is necessary for accomplishment of mobilization. The records indicate that the patient reported pain relief and improvement in function following treatments with medications, shoulder steroid injections and physical therapy. There is no documentation of severe limitation of range of motion or function of the shoulders. There is lack of guidelines and peer review data supporting the use of Posture Shirt in the treatment of chronic shoulder arthritis pain. The criteria for the purchase of Posture Shirt was not met. The request is not medically necessary.