

Case Number:	CM13-0029257		
Date Assigned:	11/01/2013	Date of Injury:	08/01/2011
Decision Date:	01/21/2014	UR Denial Date:	09/12/2013
Priority:	Standard	Application Received:	09/24/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in PM&R, and is licensed to practice in New York and Texas. 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 physician 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 47-year-old male who reported an injury on 08/01/2011. The mechanism of injury was not provided for review. The patient underwent shoulder arthroscopy with subacromial decompression, Mumford procedure and acromioplasty in 09/2012. This was followed postoperatively by physical therapy, injection therapy and massage therapy. The patient again underwent arthroscopic intra-articular release of the biceps tendon, partial labrectomy superiorly and posteriorly and arthroscopic rotator cuff repair with Mumford revision in 05/2013. This was followed by postoperative physical therapy. The patient's most recent clinical evaluation indicated that the patient was authorized for an additional surgery. The patient's physical findings included numbness in the right upper extremity at the C6-7 dermatomes, a slightly ataxic gait and a restricted cervical spine described as 50%. The patient had a positive Lhermitte's and a right positive Spurling's sign. The patient's diagnoses included musculoligamentous sprain/strain of the cervical spine, a herniated disc at the C5-6 and C6-7 and status post 2 right shoulder surgeries. The patient's treatment plan included a continuation of medications and surgical intervention.

IMR ISSUES, DECISIONS AND RATIONALES

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

Muscle stimulator: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Page(s): 116.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, post-operative pain (transcutaneous electrical nerve stimulation Page(s): 115.

Decision rationale: The requested muscle stimulator is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the patient was a surgical candidate. However, there was no indication that that surgery has actually taken place. The California Medical Treatment Utilization Schedule does recommend a TENS unit in the postoperative treatment of a patient's pain. However, the use of that equipment should be limited to approximately 30 days. The request as it is written exceeds that recommendation. There are no exceptional factors noted within the documentation to support extended treatment beyond guideline recommendations. As such, the requested muscle stimulator is not medically necessary or appropriate.

CMF spinalogic bone growth stimulator: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Low Back Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Chapter.

Decision rationale: The requested CMF SpinaLogic bone growth stimulator is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient is a surgical candidate. The Official Disability Guidelines do recommend the use of a bone growth stimulator in instances where there is documentation of risk of delayed healing. The clinical documentation submitted for review does not provide any evidence that the patient is at risk for delayed healing. Therefore, the requested bone growth stimulator would not be medically necessary or appropriate.

Hot/cold contrast therapy unit: 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 Official Disability Guidelines (ODG), Neck and Upper Back Chapter, Continuous-flow cryotherapy.

Decision rationale: The requested hot/cold contrast therapy unit is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the patient is a surgical candidate. However, the Official Disability Guidelines do not recommend the use of continuous flow cryotherapy in the postsurgical management of a neck injury. As such, the requested hot/cold contrast therapy unit is not medically necessary or appropriate.