

Case Number:	CM14-0007899		
Date Assigned:	04/07/2014	Date of Injury:	08/09/2013
Decision Date:	05/27/2014	UR Denial Date:	01/06/2014
Priority:	Standard	Application Received:	01/21/2014

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 Anesthesiology, has a subspecialty in Pain Management 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 an employee of [REDACTED] and has submitted a claim for right shoulder pain with an industrial injury date of August 9, 2013. Treatment to date has included medications, acupuncture, home exercise program, right shoulder cortisone injection, and an unknown number of physical therapy sessions, which provided benefit. Utilization review from January 6, 2014 denied the request for MRI arthrogram with contrast right shoulder because a repeat MRI was not warranted; physical therapy two to three times a week for 6 visits because there was no evidence of improvement; and TENS unit because the patient did not have a condition for which this would be medically necessary. Medical records from 2013 through 2014 were reviewed, which showed that the patient complained of right shoulder pain radiating to the mid-back and right shoulder blade. On physical examination, there was tenderness to palpation to the right shoulder with muscle spasm. Range of motion was limited. Impingement syndrome test was positive on the right. An MRI of the right shoulder with arthrogram dated January 17, 2014 showed minimal contrast noted in the glenohumeral joint space compromising the arthrogram study; extravasation of contrast noted in the subscapular and subcoracoid bursal space; and osteoarthropathy of acromioclavicular joint.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI ARTHROGRAM WITH CONTRAST RIGHT SHOULDER: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 207.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 557-559.

Decision rationale: According to the MTUS/ACOEM Guidelines, the criteria for MR Arthrogram include a red flag; physiologic evidence of tissue insult or neurologic dysfunction; failure to progress in a strengthening program intended to avoid surgery; and clarification of the anatomy prior to an invasive procedure. In addition, MRI and arthrography have fairly similar diagnostic and therapeutic impact and comparable accuracy although MRI is more sensitive and may be the preferred investigation because it demonstrates soft tissue anatomy better. In this case, the medical records did not indicate any red flags or failure to progress in a strengthening program. Furthermore, there was no discussion why an arthrography was requested rather than an MRI. There is also no discussion regarding the indication for arthrography. The request for a MRI arthrogram with contrast right shoulder is not medically necessary and appropriate.

PHYSICAL THERAPY 2-3 X WEEK FOR 6 VISITS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

Decision rationale: The Chronic Pain Medical Treatment Guidelines, a time-limited treatment plan with clearly defined functional goals, frequent assessment and modification of the treatment plan based upon the patient's progress in meeting those goals, and monitoring from the treating physician regarding progress and continued benefit of treatment are paramount. In this case, the patient already underwent an unknown number of physical therapy sessions; however, functional improvement and continued benefit were not documented. In addition, patients are expected to continue active therapies at home in order to maintain improvement levels. There is no indication for continued physical therapy; therefore, the request for physical therapy two to three times per week for six visits is not medically necessary and appropriate.

TENS UNIT: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-116.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, TENS units are not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option. Criteria for the use of TENS unit include chronic intractable pain, evidence that other appropriate pain modalities have been tried and failed, and a treatment plan including the specific short- and long-term goals of treatment

with the TENS unit. In this case, there was no discussion regarding failure of other pain management options. Furthermore, there was no discussion regarding treatment goals for the use of a TENS unit. There is also no specific duration or request for a trial. The request for a TENS unit is not medically necessary and appropriate.