

Case Number:	CM14-0152752		
Date Assigned:	09/22/2014	Date of Injury:	08/29/2009
Decision Date:	11/26/2014	UR Denial Date:	08/22/2014
Priority:	Standard	Application Received:	09/18/2014

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 Occupational Medicine 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 injured worker is a 35 year old female with a date of injury on 8/29/2009. As per 7/23/14 report, she complained of right shoulder pain rated at a 7/10, numbness, cramping, tension and waking up at night due to pain, and weakness in the arm. An exam revealed decreased right shoulder range of motion (ROM), decreased motor strength at 5-/5 in external rotation and to 4/5 in abduction, decreased grip strength at 20 pounds on the right compared to 42 pounds on the left, positive Phalen's and reverse Phalen's tests on the right upper extremity, positive Tinel's at the wrist bilaterally and at the elbow on the left, tenderness along the medial and lateral epicondyle on the right and laterally on the left, tenderness along the radial tunnel bilaterally, mild tenderness along the pronator teres on the right, tenderness along the trapezius and shoulder girdle bilaterally, and pain with facet loading of the cervical spine from C3-C7. A right shoulder magnetic resonance imaging (MRI) dated 1/12/10 revealed small partial tear involving the distal subscapularis tendon and articular surface without tendon retraction and muscle atrophy. She has had right forearm surgery in 1996. She is currently on Norco, Ibuprofen, Tramadol, gabapentin, and Protonix. She has reportedly not had any physical therapy (PT), acupuncture, assistive devices, or the use of a transcutaneous electrical stimulation (TENS) unit since her injury. Diagnoses include discogenic cervical condition with facet inflammation, right shoulder impingement, rotator cuff strain, and bicipital tendonitis, element of ulnar neuritis bilaterally, carpal tunnel bilaterally, lateral greater than medial epicondylitis bilaterally, element of stress, depression, insomnia, sexual dysfunction, weight gain secondary to orthopedic injury. The request for transcutaneous electrical neural stimulation (TENS) unit right shoulder, cervical traction with air bladder, and hot and cold compression garments right shoulder was denied.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS (Transcutaneous Electrical Neural Stimulation) Unit Right Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): s 114-116.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrical nerve stimulation (TENS) Page(s): 113.

Decision rationale: According to the California Medical Treatment Utilization Schedule guidelines, transcutaneous electrical nerve stimulation (TENS) for chronic pain, is recommended as a one-month home-based transcutaneous electrical nerve stimulation (TENS) trial which may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration for neuropathic pain, including diabetic neuropathy, complex regional pain syndrome (CRPS) I and II, post-herpetic neuralgia and phantom limb pain. Additionally, the Official Disability Guidelines (ODG) criteria states that transcutaneous electrical nerve stimulation (TENS) can be used for chronic intractable pain if there is evidence of other pain modalities have been tried and failed. In this case, there is no documentation of any adjunct therapy and there is no evidence of neuropathic pain in the right shoulder. Based on the California Medical Treatment Utilization Schedule guidelines as well as the clinical documentation, therefore, the request for transcutaneous electrical nerve stimulation (TENS) is not medically necessary.

Hot and Cold Compression Garments Right 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, Shoulder, Cold Compression Therapy

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

Decision rationale: As per California Medical Treatment Utilization Schedule (MTUS) guidelines, "home, local application of cold during first few days of acute complaint, is recommended and thereafter, then heat application." As per the Official Disability Guidelines (ODG), cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries (e.g, muscle strains and contusions) has not been fully evaluated. In this case, there is no evidence of recent shoulder surgery. Per guidelines, this device is not recommended for non-surgical treatment of the shoulder pain. Therefore, the request is not medically necessary.

Cervical Traction with Air Bladder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173-174.

Decision rationale: Per the California Medical Treatment Utilization Schedule (MTUS) /American College Occupational and Environmental Medicine (ACOEM) guidelines, there is no high-grade scientific evidence to support effectiveness or ineffectiveness of passive modalities such as home traction. While traction can be used on a trial basis according to American College Occupational and Environmental Medicine (ACOEM), it needs monitoring with emphasis focusing on functional restoration and return to activities of daily living (ADLs). In this case, there is no evidence of a prior successful trial of the traction device (i.e. in physical therapy [PT]) to demonstrate the effectiveness of this device and there is no documentation of an emphasis on functional restoration and return to activities of daily living (ADLs) with its use. Therefore, the request is not medically necessary.