

Case Number:	CM14-0029840		
Date Assigned:	06/20/2014	Date of Injury:	03/15/2010
Decision Date:	08/20/2014	UR Denial Date:	02/20/2014
Priority:	Standard	Application Received:	03/10/2014

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 applicant is a represented [REDACTED] employee who has filed a claim for chronic neck pain reportedly associated with an industrial injury of March 15, 2010. Thus far, the applicant has been treated with the following: Analgesic medications; attorney representation; transfer of care to and from various providers in various specialties; earlier shoulder surgery; a 26% whole-person impairment rating; unspecified amounts of chiropractic manipulative therapy; and the apparent imposition of permanent work restrictions. In a Utilization Review Report of February 10, 2014, the claims administrator denied a shoulder MRI, approved a heating pad, and denied a pro-tech multi-stimulator unit. The applicant's attorney subsequently appealed. On February 6, 2014, the applicant apparently transferred care to a new primary treating provider, presenting with neck pain, low back pain, shoulder pain, wrist pain, ankle pain, poor concentration, poor memory, sleep disturbance, anxiety, and sexual dysfunction. The applicant was placed off of work, on total temporary disability. Authorization was sought for osteopathic manipulative therapy, chiropractic manipulative therapy, medical transportation, medications, pro-tech multi stimulator unit, a heating pad, and MRI imaging of the shoulder. The applicant, it was incidentally noted, was described as having pain limited shoulder range of motion with flexion to 100 degrees. The applicant was described as having right shoulder pain status post right shoulder surgery on March 29, 2011 and has, furthermore, had MR arthrography of February 13, 2013 demonstrating partial thickness supraspinatus and infraspinatus tears.

IMR ISSUES, DECISIONS AND RATIONALES

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

An MRI of the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 214.

Decision rationale: As noted in the MTUS-adopted ACOEM Guidelines in Chapter 9, Table 9-6, page 214, routine MRI arthrography of the shoulder for evaluation purposes without surgical indications is not recommended. In this case, there is no indication that the applicant is actively considering or contemplating a shoulder surgery. There is no description how shoulder MRI imaging would alter the treatment plan. Furthermore, the attending provider acknowledged that the applicant had already had earlier shoulder MR arthrography, which did definitively establish a diagnosis of partial thickness rotator cuff tears, multiple. It is unclear why repeat shoulder MRI imaging is being sought, if the applicant already has a definitive diagnosis insofar as the shoulder is concerned. Therefore, the request is not medically necessary.

Purchase of a ProStim multi stim unit for the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203, Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation) Page(s): 114.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular Electrical Stimulation topic Page(s): 121. Decision based on Non-MTUS Citation Multi Stim Unit - Post Surgical Rehab Specialists www.postsurgicalrehab.com/pdf/MSUandMicroZ.pdf.

Decision rationale: Per the product description, the proposed multi-stimulator unit contains three forms of therapy, namely conventional TENS therapy, interferential stimulator unit, and neuromuscular stimulation. However, neuromuscular stimulation, per page 121 of the MTUS Chronic Pain Medical Treatment Guidelines is not recommended outside of the post-stroke rehabilitative context. A neuromuscular stimulation is not, thus, recommended in the chronic pain context present here. The request is not medically necessary.