

Case Number:	CM14-0046649		
Date Assigned:	07/02/2014	Date of Injury:	06/14/2010
Decision Date:	08/01/2014	UR Denial Date:	04/11/2014
Priority:	Standard	Application Received:	04/14/2014

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 Physical Medicine and Rehabilitation 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 39-year-old female with a reported injury on 02/22/2010 and also an injury on 06/14/2010. The mechanism of either one of those injuries was not provided. The injured worker had an examination on 04/21/2014 because of her right shoulder. She was asked to get additional information regarding the subacromial injection. It is on the report that she had never had any lab work before. The examination of the right shoulder did reveal a well healed surgical scar from a previous surgery, tenderness and palpation over the subacromial region. Her cross arm test and impingement test was positive, crepitus was present, and the range of motion of the right shoulder showed flexion as 100 degrees, extension as 90 degrees, abduction is 95 degrees, adduction is 30 degrees, internal rotation is 60 degrees and external rotation is 65 degrees. Her weakness scale was 4/5 in all of her planes of motion. Her medication list was not provided nor was the efficacy of her medications. There is no record of past previous treatments of any physical therapy, home exercise program, or the use of medications. Her diagnoses consisted of cervicothoracic muscle ligamentous sprain/strain with right upper extremity radiculitis, mild bilateral neural foraminal narrowing at C6-7 and multilevel facet hypertrophy. The treatment plan is to make sure that she has an adequate supply of her medications, again, which was not listed and an MRI scan of the lumbar spine. There is no mention on this note at all regarding her TENS unit or her injection to the subacromial region. The request for authorization and the rationale was not provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS Unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain(transcutaneous electrical nerve stimulation).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guideline, TENS, chronic pain 114-116 Page(s): 114-116.

Decision rationale: The request for the TENS unit is not medically necessary. According to the California MTUS Guidelines, the TENS unit is not recommended as a primary treatment modality. The guidelines state that the criteria for the TENS unit is documentation of pain of at least 3 months duration and evidence that other appropriate pain modalities have been tried including medication and have failed. There is no evidence of any medication or the efficacy of the medication or whether they have been effective or whether they have failed. There is no documentation or evidence of any functional deficits. Furthermore, the TENS unit request does not specify which part of the body for it to be put on and also for frequency and duration of it. Therefore, the request for the TENS unit is not medically necessary.

Right Shoulder Ultrasound Guided Injection to the Subacromial region: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204,Chronic Pain Treatment Guidelines ShoulderCriteria for Steroid Injections.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 212-214.

Decision rationale: The right shoulder ultrasound guided injection to the subacromial region is not medically necessary. There is no specification of the exact type of injection. The American College of Occupational and Environmental Medicine mention that two or three sub-acromial injections of local anesthetic and cortisone prepartation over an extended period is part of an exercise rehabilitation program to treat rotator cuff inflammation, impingement syndrome, or small tears. The documentation does not have evidence of an exercise rehabilitation program. There is no evidence of rotator cuff inflammation or impingement syndrome. Therefore, the request is not medically necessary.