

Case Number:	CM14-0057949		
Date Assigned:	07/09/2014	Date of Injury:	05/22/2012
Decision Date:	09/09/2014	UR Denial Date:	04/23/2014
Priority:	Standard	Application Received:	04/29/2014

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 patient is a 46-year-old male who has submitted a claim for status post left rotator cuff repair with recurrent instability, status post revision surgery of the left shoulder, status post left shoulder failed twice, right shoulder internal derangement, left rotator cuff syndrome, left shoulder recurrent dislocation, anesthesia complications, weight gain, right triangular fibrocartilage complex tear, and right shoulder impingement associated with an industrial injury date of May 22, 2012. Medical records from 2013-2014 were reviewed. The patient complained of bilateral shoulder and right wrist pain. The pain awakens him at night. Physical examination showed left shoulder subacromial tenderness. Range of motion of the bilateral shoulders was limited. Crepitus was noted upon movement and impingement test was positive bilaterally. Phalen's and Tinel's test were positive on the right. MRI of the left shoulder, dated January 27, 2014, revealed prior rotator cuff surgery with no evidence of recurrent rotator cuff tear, prior tear of the superior labrum and attachment of the tendon for long head of biceps with no anchoring of the biceps tendon identified with the bicipital tendon at the level of the upper bicipital groove, old Hill-Sachs deformity of the humeral head, degenerative changes of the bony glenoid, prior acromioplasty, and anterior labrum is very small and degenerated by not plane of tear is seen. MRI of the right shoulder dated January 27, 2014, showed supraspinatus tendinosis with no rotator cuff tear, and mild AC joint degenerative changes with small inferior spur. Treatment to date has included medications, physical therapy, home exercise program, activity modification, shoulder cortisone injections, and left shoulder arthroscopic surgery. Utilization review, dated April 23, 2014, denied the request for ultrasound treatment, myofascial release, EMS, and osteopathic manipulation because all of these appear to be osteopathic treatments and because the specific body part to be treated was not specified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ultrasound treatments once per week for 6 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58-60.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ultrasound, therapeutic Page(s): 123.

Decision rationale: As stated on page 123 of the CA MTUS Chronic Pain Medical Treatment Guidelines, therapeutic ultrasound is not recommended, with little evidence that active therapeutic ultrasound is more effective than placebo ultrasound for treating pain or a range of musculoskeletal injuries or for promoting soft tissue healing. In this case, there was persistent bilateral shoulder and right wrist pain. Ultrasound was requested because according to a progress report dated April 15, 2014, it is an effective agent for the application of heat which increases circulation bringing a new nutrient blood supply as well as increasing lymphatic drainage to help clean an injured area of its waste products. However, its use is not recommended by the guidelines. Furthermore, the present request failed to specify the body part to be treated. The medical necessity has not been established. Therefore, the request for Ultrasound treatments once per week for 6 weeks is not medically necessary.

Myofascial release once per week for 6 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58-60.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Massage Therapy Page(s): 60.

Decision rationale: According to page 60 of the CA MTUS Chronic Pain Medical Treatment Guidelines, massage therapy is recommended as an option. This treatment should be an adjunct to other recommended treatment, and it should be limited to 4-6 visits in most cases. In this case, progress report dated April 15, 2014 state that myofascial release will be used to release muscular spasms that are creating tension which restricts and limits normal joint range of motion after injury. The records showed that the patient was performing physical therapy, which is a recommended treatment option; hence, massage therapy can be used as an adjunct. However, the present request failed to specify the body part to be treated. The medical necessity has not been established because the present request is incomplete. Therefore, the request for Myofascial release once per week for 6 weeks is not medically necessary.

EMS once per week for 6 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular electrical stimulation (NMES devices) Page(s): 121.

Decision rationale: According to page 121 of the CA MTUS Chronic Pain Medical Treatment Guidelines, neuromuscular electrical stimulation (NMES) devices are not recommended and are used primarily as part of a rehabilitation program following stroke. Guidelines also state that there is no evidence to support its use in chronic pain. In this case, the patient had persistent shoulder and right wrist pain. According to a progress report dated April 15, 2014, electronic muscle stimulation was requested to elicit passive muscle contractions to stimulate new nutrient blood supply, and lymphatic drainage by stimulating motor units using electric impulses to contract skeletal muscles. There was discussion regarding the indication for use of EMS despite it not being recommended by the guidelines. However, the present request failed to specify the body part to be treated. Therefore, the request for EMS once per week for 6 weeks is not medically necessary.

Osteopathic manipulation 1-2 regions once per week for 5 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58-60.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Manipulation.

Decision rationale: Manual therapy and manipulation for chronic pain if caused by musculoskeletal conditions. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. The time to produce effects is 4 to 6 treatments. Treatment beyond this should be documented with objective improvement in function. In addition, ODG allows 9 chiropractic sessions over 8 weeks for sprains and strains of shoulder and upper arm. Fading of treatment is recommended to allow self-directed home therapy. In this case, the patient has persistent shoulder and right wrist pain. The rationale of this request was to address increasing pain and restriction of motion in the neck and left scapular region since the symptoms of somatic dysfunction are triggered by the underlying internal derangement of the shoulder. The request for 1-2 regions per week for 5 weeks may be necessary. However, the present request failed to specify the particular regions as well as the body part to be treated. Therefore, the request for Osteopathic manipulation 1-2 regions once per week for 5 weeks is not medically necessary.