

Case Number:	CM14-0006124		
Date Assigned:	03/03/2014	Date of Injury:	05/13/2013
Decision Date:	02/04/2015	UR Denial Date:	12/12/2013
Priority:	Standard	Application Received:	01/13/2014

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:

Patient is a 24 year-old male with date of injury 05/13/2013. The medical document associated with the request for authorization, a primary treating physician's progress report, dated 11/04/2013, lists subjective complaints as pain in the left shoulder, neck, and upper back. MRI of the left shoulder on 07/30/2013 was positive for instability and posterior subluxation of the humerus. Objective findings: Cervical spine: There was tenderness on the cervical spine at C4 through C7 and associated paraspinal muscles, levator scapulae, and upper trapezius bilaterally. Left shoulder: Muscle testing was 4/5 in flexion, abduction, and internal and external rotation. There was pain with range of motion. Positive impingement sign on the left. Right wrist: Tenderness in the right first CMC joint. Positive Finklestein's on the right. Positive Tinel's sign at the carpal tunnel and tunnel of Guyon and to the cubital tunnel. Diagnosis: 1. Left shoulder dislocation 2. Cervical spine myofascitis 3. Right shoulder arthroscopy 4. Left shoulder instability 5. Headaches. There was no documentation for the patient ever having attended physical therapy in the records supplied for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy for left shoulder x 6: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-60.

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines state that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. The patient is apparently undergone several full courses of physical therapy, but there is no documentation of the efficacy of previous therapy or of any functional improvement. Six (6) sessions of physical therapy for the left shoulder is not medically necessary.

Spirometry and Pulmonary Function: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pulmonary

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pulmonary (Acute & Chronic), Pulmonary function testing

Decision rationale: The Official Disability Guidelines recommend spirometry and pulmonary function testing of the diagnosis and management of chronic lung diseases, most notably asthma. In addition, pulmonary function testing it is sometimes utilized in a preoperative evaluation of a patient with pulmonary compromise. There is no documentation of any of the above criteria. Spirometry and pulmonary function testing is not medically necessary.

Stress Testing: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pulmonary

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pulmonary (Acute & Chronic), Pulmonary function testing

Decision rationale: The Official Disability Guidelines recommend the use of a bronchoconstricting agent in testing for asthma. Use of a bronchoconstricting agent is termed "bronchoprovocation" and commonly used agents include chemical agents (acetylcholine, methacholine, and putative occupational chemical exposures), physical agents (cold air, dry air), and exercise. Also useful in asthmatics is the use of peak flow meters to determine the presence of asthma, the response to treatment, and exacerbations of asthma. There is no documentation of work-related pulmonary or cardiac history which would warrant any stress test. Stress testing is not medically necessary.

SDBR Study Including Pulse Oximetry and Nasal Function Studies: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Polysomnography

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic), Polysomnography

Decision rationale: According to the Official Disability Guidelines, in-lab polysomnograms / sleep studies are recommended for the combination of indications listed below: (1) Excessive daytime somnolence; (2) Cataplexy (muscular weakness usually brought on by excitement or emotion, virtually unique to narcolepsy); (3) Morning headache (other causes have been ruled out); (4) Intellectual deterioration (sudden, without suspicion of organic dementia); (5) Personality change (not secondary to medication, cerebral mass or known psychiatric problems); & (6) Insomnia complaint for at least six months (at least four nights of the week), unresponsive to behavior intervention and sedative/sleep-promoting medications and psychiatric etiology has been excluded. A sleep study for the sole complaint of snoring, without one of the above mentioned symptoms, is not recommended. This request is not medically necessary.

Interspec IF II and Supplies: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential current stimulation (ICS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential current stimulation (ICS) Page(s): 118-120.

Decision rationale: According to the MTUS Chronic Pain Medical Treatment Guidelines, an interferential current stimulation (ICS) is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. A TENS unit without interferential current stimulation is the recommended treatment by the MTUS. Interspec IF II and supplies is not medically necessary.