

Case Number:	CM14-0186243		
Date Assigned:	11/14/2014	Date of Injury:	08/21/2012
Decision Date:	01/02/2015	UR Denial Date:	10/21/2014
Priority:	Standard	Application Received:	11/10/2014

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 Neurology, has a subspecialty in Neuromuscular Medicine and is licensed to practice in New Jersey. 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 40-year-old man who sustained work related injury on August 21, 2012. He subsequently developed a chronic shoulder pain. According to the progress report dated October 15, 2014, the patient complained of constant moderate 4-6/10 right shoulder pain. Relevant objective exam findings included right shoulder range of motion: flexion 94 degrees, extension 23 degrees, abduction 91 degrees, adduction 56 degrees, internal rotation 34 degrees, and external rotation 38 degrees. There was +3 tenderness and spasm in the right upper trapezius, supraspinatus, deltoid, and pec major muscles. Right upper motor strength and sensation was also decreased. Supraspinatus press test and frozen shoulder test were both positive on the right. The patient was diagnosed with status post right shoulder surgery, adhesive capsulitis of the shoulder, internal derangement right knee, and status post left knee surgery. The provider requested a 12 functional restoration manual therapy sessions and 12 EMS infrared.

IMR ISSUES, DECISIONS AND RATIONALES

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

12 functional restoration manual therapy sessions: 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 Chronic pain programs (functional restoration programs) Page(s): 31-33.

Decision rationale: According to MTUS guidelines, there is no documentation that the patient has a functional deficit that requires more FRP and he is more a candidate for a full independent home rehabilitation program. Furthermore, there is no documentation of the objectives and goals of the prescribed FRP. Therefore, the prescription of FRP is not medically necessary.

12 EMS infrared: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Electrical Stimulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Percutaneous Electrical Nerve Stimulation Page(s): 97.

Decision rationale: According to MTUS guidelines, EMS is not recommended as primary treatment modality, but a one month based trial may be considered, if used as an adjunct to a functional restoration program. It could be recommended as an option for acute post operative pain in the first 30 days after surgery. There is no documentation that a functional restoration program will parallel the use of EMS. There is no clear justification of continuous use of EMS. Therefore, the request of 12 EMS infrared is not medically necessary.