

Case Number:	CM15-0015136		
Date Assigned:	02/03/2015	Date of Injury:	03/26/2012
Decision Date:	04/23/2015	UR Denial Date:	01/05/2015
Priority:	Standard	Application Received:	01/27/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 57-year-old female, who sustained a work related injury on 3/26/12. The diagnoses have included right shoulder rotator cuff tear and subacromial impingement, right shoulder surgery-decompression and previous right shoulder surgery. Treatments to date have included 12 sessions of physical therapy, oral medications, and right shoulder surgery x 2. In the PR-2 dated 12/23/14, the injured worker complains of persistent pain in her left shoulder. She rates the pain a 6-8/10. On 1/6/15, Utilization Review non-certified requests for a TENS unit and MR arthrogram with contrast left shoulder. The California MTUS, Chronic Pain Treatment Guidelines, and ACOEM Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS unit for trapezius and deltoid muscles: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 114-116. Decision based on Non-MTUS Citation Official disability guidelines Pain Chapter. TENS, chronic pain (transcutaneous electrical nerve stimulation).

Decision rationale: Based on the 12/23/14 progress report provided by the treating physician, this patient presents with persistent left shoulder pain rated 6-8/10 on VAS scale, which is frequent and same as last month. The treater has asked for TENS UNIT FOR TRAPEZIUS AND DELTOID MUSCLES on 12/23/14. The requesting progress report dated 12/23/14 further specifies: "I would also like to request a 30-day trial of the TENS unit for the trapezius and deltoid muscles in an attempt to decrease her pain and increase functionality" and also states the patient "does continue with significant neuropathic pain." The patient's diagnoses per Request for Authorization form dated 12/26/14 were right shoulder rotator cuff tear and subacromial impingement, s/p right shoulder operative decompression, history of previous right shoulder dislocation and surgery. The patient is s/p right shoulder surgery for rotator cuff tear but the date was not specified per review of reports dated 7/24/14 to 12/23/14. The patient had 12 sessions of physical therapy with no improvement per 12/23/14 report. The patient states that Norco takes her pain down from 8/10 to 4/10, and that she has GI upset secondary to Ibuprofen use per 12/23/14 report. The patient is currently approved to return to work with restrictions. Per MTUS Guidelines page 116, TENS unit have not proven efficacy in treating chronic pain and is not recommend as a primary treatment modality, but a 1-month home-based trial may be considered for a specific diagnosis of neuropathy, CRPS, spasticity, a phantom limb pain, and multiple sclerosis. When a TENS unit is indicated, a 30-day home trial is recommended, and with the documentation of functional improvement, additional usage maybe indicated. The treater is requesting a TENS unit trial for the trapezius and deltoid muscles in an attempt to decrease her pain and increase functionality. Review of the reports do not show any evidence of a TENS unit being used in the past. In this case, the patient does not have a diagnosis of Neuropathic pain, Phantom limb pain, CRPS, Spasticity or Multiple sclerosis. The requested TENS unit trial is not indicated for this type of condition. The request IS NOT medically necessary.

MR arthrogram with contrast for the left shoulder: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Shoulder chapter, MR Arthrography.

Decision rationale: Based on the 12/23/14 progress report provided by the treating physician, this patient presents with persistent left shoulder pain rated 6-8/10 on VAS scale, which is frequent and same as last month. The treater has asked for MR ARTHROGRAM WITH CONTRAST FOR THE LEFT SHOULDER on 12/23/14 "due to the persistent pain, decreased functionality and failing of physical therapy post-operatively". To rule out a re-tear and other internal derangement. The requesting progress report dated 12/23/14 further specifies: "I would also like to request a 30-day trial of the TENS unit for the trapezius and deltoid muscles in an

attempt to decrease her pain and increase functionality." The patient's diagnoses per Request for Authorization form dated 12/26/14 were right shoulder rotator cuff tear and subacromial impingement, s/p right shoulder operative decompression, history of previous right shoulder dislocation and surgery. The patient is s/p right shoulder surgery for rotator cuff tear but the date was not specified per review of reports dated 7/24/14 to 12/23/14, and neither was it mentioned in utilization review letter dated 1/5/15. The patient had 12 sessions of physical therapy with no improvement per 12/23/14 report. The patient states that Norco takes her pain down from 8/10 to 4/10, and that she has GI upset secondary to Ibuprofen use per 12/23/14 report. The patient is currently approved to return to work with restrictions. Official Disability Guidelines (ODG) Shoulder chapter. Topic: MR Arthrography. October 2014 Update states the following: "Recommended as an option to detect labral tears, and for suspected re-tear post-op rotator cuff repair. MRI is not as good for labral tears, and it may be necessary in individuals with persistent symptoms and findings of a labral tear that a MR arthrogram is performed even with negative MRI of the shoulder, since even with a normal MRI, a labral tear may be present in a small percentage of patients. Direct MR orthography can improve detection of labral pathology. (Murray, 2009) If there is any question concerning the distinction between a full-thickness and partial-thickness tear, MR orthography is recommended. It is particularly helpful if the abnormal signal intensity extends from the undersurface of the tendon. (Steinbach, 2005)." Review of the reports does not show any evidence of a prior MR arthrogram of the left shoulder being done in the past. In this case, the patient had an injury in 2012, and has persistent symptoms despite a rotator cuff surgery of unspecified date. Regarding MR Arthrograms, ODG shoulder chapter states they are recommended as an option to detect labral tears, and for suspected re-tear post-op rotator cuff repair. The treater's request appears reasonable for the patient's ongoing left shoulder pain. The request IS medically necessary. Review of the reports do not show any evidence of a prior MR arthrogram of the left shoulder being done in the past. In this case, the patient had an injury in 2012, and has persistent symptoms despite a rotator cuff surgery of unspecified date. Regarding MR Arthrograms, ODG shoulder chapter states they are recommended as an option to detect labral tears, and for suspected re-tear post-op rotator cuff repair. The treater's request appears reasonable for the patient's ongoing left shoulder pain. The request IS medically necessary.