

Case Number:	CM15-0025911		
Date Assigned:	02/18/2015	Date of Injury:	12/17/2012
Decision Date:	04/07/2015	UR Denial Date:	01/12/2015
Priority:	Standard	Application Received:	02/11/2015

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 44 year old male who sustained an industrial injury on 12/17/12. The injured worker reported symptoms in the right shoulder. The diagnoses included right shoulder impingement syndrome, right shoulder internal derangement, right shoulder sprain/strain and right shoulder tenosynovitis. Treatments to date include oral pain medications. In a progress note dated 10/14/14 the treating provider reports the injured worker was with complaints of "constant severe sharp, throbbing right shoulder pain, stiffness and weakness. The ranges of motion are decreased and painful." On 1/12/15 Utilization Review non-certified the request for an arm sling purchase, transcutaneous electrical nerve stimulation unit, right wrist brace purchase and motorized cold therapy purchase. The MTUS, ACOEM Guidelines, (or ODG) was cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Arm Sling-purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Shoulder, post-operative abduction pillow.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints
Page(s): 204.

Decision rationale: The patient was injured on 12/17/12 and presents with pain in his right wrist, elbow, and shoulder. The request is for an ARM SLING PURCHASE. There is no RFA provided and the patient is temporarily totally disabled. The report with the request is not provided nor is there any discussion provided regarding this request. ACOEM guidelines Shoulder chapter, Chapter: 9, page 204: Under Options, it allows for "Sling for acute pain," under rotator cuff tear and as a "sling for comfort," for AC joint strain or separation. The 12/08/14 report states that the patient has tenderness to palpation of the acromioclavicular joint, anterior shoulder, lateral shoulder, and posterior shoulder. Supraspinatus press is positive. There is WHSS x 1 at the right elbow, decreased ulnar and median nerve sensation, a positive Cozen's, and a painful range of motion. For the right wrist, there is tenderness to palpation of the dorsal wrist, lateral wrist, medial wrist, and volar wrist. Both Finkelstein's and Phalen's are positive. The patient is diagnosed with right shoulder impingement syndrome, right shoulder internal derangement, right shoulder pain, and right shoulder sprain/strain. The injury date is 2-years ago and does not appear to be acute in nature. The ACOEM guidelines support the use of a sling for rotator cuff tears and for acute pain. It does not appear that there are any future surgeries planned, nor have there been any recent surgeries performed. Given that the patient does not present with a rotator cuff tear or acute pain, the requested arm sling IS NOT medically necessary.

TENS Unit: Upheld

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

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

Decision rationale: The patient was injured on 12/17/12 and presents with pain in his right wrist, elbow, and shoulder. The request is for an TENS UNIT. There is no RFA provided and the patient is temporarily totally disabled. The report with the request is not provided nor is there any discussion provided regarding this request. Per MTUS guidelines page 116, TENS unit have not proven efficacy in treating chronic pain and is not recommended as a primary treatment modality, but a 1-month home-based trial may be considered for a specific diagnosis of neuropathy, CRPS, spasticity, phantom limb pain, and multiple sclerosis. When a TENS unit is indicated, a 30-day home trial is recommended, and with documentation of functional improvement, additional usage may be indicated. The 12/08/14 report states that the patient has tenderness to palpation of the acromioclavicular joint, anterior shoulder, lateral shoulder, and posterior shoulder. Supraspinatus press is positive. There is WHSS x 1 at the right elbow, decreased ulnar and median nerve sensation, a positive Cozen's, and a painful range of motion. For the right wrist, there is tenderness to palpation of the dorsal wrist, lateral wrist, medial wrist, and volar wrist. Both Finkelstein's and Phalen's are positive. The patient is diagnosed with right shoulder impingement syndrome, right shoulder internal derangement, right shoulder pain, and right shoulder sprain/strain. In this case, there is no mention of the patient previously using the

TENS unit for a 1-month trial as required by MTUS guidelines. There are no discussions regarding any outcomes for pain relief and function. The patient does present with radicular symptoms and a trial of TENS may be reasonable. However, without a one-month trial, a home unit is not recommended per MTUS. The request IS NOT medically necessary.

Right Wrist Brace-purchase: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Foreman, Wrist & Hand, splints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 264.

Decision rationale: The patient was injured on 12/17/12 and presents with pain in his right wrist, elbow, and shoulder. The request is for a RIGHT WRIST BRACE PURCHASE. There is no RFA provided and the patient is temporarily totally disabled. The report with the request is not provided nor is there any discussion provided regarding this request. MTUS/ ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11, Forearm, Wrist, and Hand Complaints, page 264, under Initial Care states: Initial treatment of CTS should include night splints. Day splints can be considered for patient comfort as needed to reduce pain, along with work modifications. The 12/08/14 report states that the patient has tenderness to palpation of the acromioclavicular joint, anterior shoulder, lateral shoulder, and posterior shoulder. Supraspinatus press is positive. There is WHSS x 1 at the right elbow, decreased ulnar and median nerve sensation, a positive Cozen's, and a painful range of motion. For the right wrist, there is tenderness to palpation of the dorsal wrist, lateral wrist, medial wrist, and volar wrist. Both Finkelstein's and Phalen's are positive. The patient is diagnosed with right shoulder impingement syndrome, right shoulder internal derangement, right shoulder pain, and right shoulder sprain/strain. In this case, the physician notes a positive Phalens test, which is suggestive of carpal tunnel syndrome. Therefore, the requested right wrist brace purchase IS medically necessary.

Motorized Cold Therapy-purchase: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-Continuous-flow cryotherapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Pain Chapter under continuous flow cryotherapy.

Decision rationale: The patient was injured on 12/17/12 and presents with pain in his right wrist, elbow, and shoulder. The request is for a MOTORIZED COLD THERAPY PURCHASE. There is no RFA provided and the patient is temporarily totally disabled. The report with the request is not provided nor is there any discussion provided regarding this request. The MTUS and ACOEM Guidelines do not discuss water therapy units. ODG Guidelines Pain Chapter under continuous flow cryotherapy states, "Recommended as an option after surgery, but not for

nonsurgical treatment. Postoperative use generally may be up to 7 days including home use. In a postoperative setting, continuous flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic use. However, the effectiveness on more frequently treated acute injuries has not been fully evaluated." The treater does not provide a reason for the request. There is no indication for any upcoming surgery the patient may have. In this case, ODG Guidelines do not support this type of device other than for postoperative recovery, which the patient has not had nor is scheduled for. The requested motorized cold therapy unit purchase IS NOT medically necessary.