

Case Number:	CM15-0040903		
Date Assigned:	03/11/2015	Date of Injury:	06/29/2010
Decision Date:	04/21/2015	UR Denial Date:	01/28/2015
Priority:	Standard	Application Received:	03/04/2015

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 58-year-old female, who sustained an industrial injury on 06/29/2010. On provider visit dated 08/05/2014 the injured worker has reported trigger fingers, neck pain and shoulder pain. On examination, she was noted to have triggering of middle finger, Phalen's test was positive, pain and tenderness radically was noted, Finkelstein's test was positive, and decreased range of motion with pain of left shoulder was noted. The diagnoses have included status post left shoulder surgery with residual, status post left de Quervain's release with residual and ongoing symptoms, left thumb complaints and burning and history of trigger finger. Treatment to date has included modified duties, further treatment including surgery, trigger finger release and follow up care. There was limited documentation submitted for this medical review.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Transcutaneous Electrical Nerve Stimulator (TENS): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints, Chronic Pain Treatment Guidelines TENS.

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

Decision rationale: Based on the 08/06/14 progress report provided by treating physician, the patient presents with triggering of the fingers, neck pain and shoulder pain. The request is for 1 TRANSCUTANEOUS ELECTRICAL NERVE STIMULATOR (TENS). The patient is status post left shoulder surgery and left de Quervain's release with residual and ongoing symptoms. RFA not provided. Patient's diagnosis on 08/06/14 includes left thumb complaints and burning, and history of triggering left middle finger. Treatment to date has included physical therapy, modified duties, aforementioned surgeries and follows up care. The patient is working full duty, per treater report dated 08/06/14. According to MTUS Chronic Pain Management Guidelines the criteria for use of TENS in chronic intractable pain (p116) "a one month trial period of the TENS unit should be documented (as an adjunct to other treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function during this trial."Treater has not provided reason for the request, indicated whether unit is for rental or home use, nor indicated what body part would be treated. Available medical records provided limited documentation. There is no record that patient has trialed a TENS unit in the past. MTUS requires documentation of one month prior to dispensing home units. Furthermore, patient does not present with an indication for TENS unit. MTUS supports units for neuropathic pain, spasticity, MS, phantom pain and others. The request is not in accordance with guideline indications. Therefore, the request IS NOT medically necessary.

Hand Exercise Kit: 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, Exercise kit Low Back Chapter under Exercise.

Decision rationale: Based on the 08/06/14 progress report provided by treating physician, the patient presents with triggering of the fingers, neck pain and shoulder pain. The request is for HAND EXERCISE KIT. The patient is status post left shoulder surgery and left de Quervain's release with residual and ongoing symptoms. RFA not provided. Patient's diagnosis on 08/06/14 includes left thumb complaints and burning, and history of triggering left middle finger. Treatment to date has included physical therapy, modified duties, aforementioned surgeries and follows up care. The patient is working full duty, per treater report dated 08/06/14.Exercise is recommended in MTUS, ACOEM, and ODG guidelines.ODG supports "exercise kit" under Shoulder Chapter. "Home exercise kits are recommended where home exercise and active self-directed home physical therapy is recommended. ODG guidelines, Low Back Chapter under Exercise states that "exercise is recommended for treatment and prevention. Key to success is physical activity in any form rather than through any specific activity."Treater has not provided reason for the request. Available medical records provided limited documentation. In this case, the patient is status post shoulder surgery and continues with pain to the upper extremity. Given

the strong support for exercise in general, and a specific recommendation for exercise kit found under shoulder chapter, the current request appears reasonable. The patient does present with shoulder pain as well. Therefore, the request IS medically necessary.

Arm Sling, left arm: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment for Workers' Compensation: Chapter -Shoulder (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204. Decision based on Non-MTUS Citation Official disability guidelines Shoulder Chapter, Immobilization.

Decision rationale: Based on the 08/06/14 progress report provided by treating physician, the patient presents with triggering of the fingers, neck pain and shoulder pain. The request is for ARM SLING, LEFT ARM. The patient is status post left shoulder surgery and left de Quervain's release with residual and ongoing symptoms. RFA not provided. Patient's diagnosis on 08/06/14 includes left thumb complaints and burning, and history of triggering left middle finger. Treatments to date has included physical therapy, modified duties, aforementioned surgeries and follow up care. The patient may continue to work regular duty, per treater report dated 08/06/14. ACOEM: 2nd Edition, (2004) Chapter 9, page 204, table 9-3, Recommendations under Options for Rotator Cuff tear, Shoulder Sling: ACOEM recommends as an option for Rotator Cuff tear: ?Sling for acute pain or for AC joint strain Sling for comfort. ODG guidelines Shoulder Chapter, under Immobilization states: Not recommended as a primary treatment. Immobilization and rest appear to be overused as treatment. Early mobilization benefits include earlier return to work; decreased pain, swelling, and stiffness; and a greater preserved range of joint motion, with no increased complications. Postoperative abduction pillow sling topic states, Recommended as an option following open repair of large and massive rotator cuff tears. Treater has not provided reason for the request. Available medical records provided limited documentation. In this case, patient continues with shoulder pain and postoperative use of sling would be supported by guidelines. The ACOEM guidelines support the use of a sling for rotator cuff tears. However, treater has not specified date of surgery, nor indicated the procedure. Patient does not present with a diagnosis of rotator cuff tear for which the sling would be indicated, either. Furthermore, ODG does not recommend sling as a primary treatment. Therefore, the request IS NOT medically necessary.