

<b>Case Number:</b>	CM15-0041474		
<b>Date Assigned:</b>	03/11/2015	<b>Date of Injury:</b>	02/02/2012
<b>Decision Date:</b>	04/14/2015	<b>UR Denial Date:</b>	02/12/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	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: Illinois, California, Texas  
 Certification(s)/Specialty: Orthopedic Surgery

### 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 60-year-old female who sustained an industrial injury on 2/2/12, relative to a fall. The 12/22/14 right shoulder MRI findings documented supraspinatus tendinosis and peritendinitis with no rotator cuff tear. There was tenosynovitis of the long head of the biceps tendon, acromioclavicular (AC) joint arthropathy, and mild glenohumeral joint osteoarthritic changes. The 1/2/15 treating physician report cited constant grade 6/10 anterior right shoulder pain. Pain was increased with reaching, lifting, pushing, and pulling activities. Pain was decreased with rest, home exercise program, and medications. Right shoulder exam documented subacromial, supraspinatus, AC joint, and periscapular tenderness. There was muscle guarding, crepitus, and decreased range of motion in all planes. There was positive impingement. Surgical consultation was recommended. The 2/12/15 utilization review determination certified the request for right shoulder surgery, cold therapy unit purchase, and pre-operative medical clearance. The request for Robaxin 750 mg #120 was modified to Robaxin 750 mg #20 as there was no documentation of muscle spasms or exacerbation of low back pain, and to allow for weaning. The request for shoulder continuous passive motion (CPM) rental for 45 days was denied as the patient was not undergoing supported procedures. The request for SurgiStim unit rental for 90 days was non-certified as there was no indication that post-op physical therapy would not adequately address post-operative pain.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Robaxin 750 mg #120:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-65.

**Decision rationale:** The California MTUS recommends the use of non-sedating muscle relaxants, such as Robaxin, with caution as a second line option for short term treatment of acute exacerbations in patients with chronic lower back pain. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. Guideline criteria have not been met. There is no current documentation of muscle spasms or an exacerbation of low back pain. There is no specific documentation relative to the length of use of this medication. The 2/12/15 utilization review partially certified this request for Robaxin 750 mg #20 to allow for medication tapering. There is no compelling reason to support the medical necessity of additional medication in the absence of a documented low back pain flare, current muscle spasms, and prior benefit. Therefore, this request is not medically necessary.

**Shoulder CMP rental for 45 days:** 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).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder: Continuous passive motion (CPM).

**Decision rationale:** The California MTUS does not provide recommendations for continuous passive motion (CPM) following shoulder surgery. The Official Disability Guidelines state that CPM is not recommended for shoulder rotator cuff problems or after shoulder surgery, except in cases of adhesive capsulitis. Guideline criteria have not been met. There is no current evidence that this patient has adhesive capsulitis. Prophylactic use of continuous passive motion in shoulder surgeries is not consistent with guidelines. Therefore, this request is not medically necessary.

**Surgi stim unit rental for 90 days:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-121.

**Decision rationale:** The SurgiStim unit provides a combination of interferential current, neuromuscular electrical stimulation (NMES), and galvanic current. The California MTUS guidelines for transcutaneous electrotherapy do not recommend the use of NMES in the treatment of chronic pain. Galvanic stimulation is considered investigational for all indications. Guidelines suggest that interferential current is not recommended as an isolated intervention. Patient selection criteria is provided if interferential stimulation is to be used despite lack of guideline support and includes ineffective pain control due to diminished effectiveness of medications, intolerance of medications, history of substance abuse, post-operative pain limiting functional ability, and failure to respond to conservative measures. Guideline criteria have not been met. There is no indication that standard post-op pain management would be insufficient. There is no documentation that the patient was intolerant or unresponsive to pain medications during the pre-operative period. If one or more of the individual modalities provided by this multi-modality unit is not supported (as in this case), then the unit as a whole is not supported. Therefore, this request is not medically necessary.