

Case Number:	CM14-0148752		
Date Assigned:	09/18/2014	Date of Injury:	08/11/2011
Decision Date:	10/20/2014	UR Denial Date:	08/26/2014
Priority:	Standard	Application Received:	09/12/2014

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 Orthopedic Surgeon and is licensed to practice in Texas and Colorado. 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 injured worker is a 56-year-old male who reported a date of injury of 08/11/2011. The mechanism of injury was not indicated. The injured worker had diagnoses of status post right de Quervain's release with residual symptomology, cervical radiculitis, left shoulder tendinitis, and left lateral and medial epicondylitis. Prior treatments included physical therapy and the use of a TENS unit. The injured worker had MRIs and electrodiagnostic studies of unknown dates and findings. Surgeries included de Quervain's release of unknown date. The injured worker had complaints of constant severe cervical spine pain, constant severe pulsating sensations of the shoulders bilaterally, and complaints of constant severe pain to the hands and wrists bilaterally. The clinical note dated 07/15/2014 noted the injured worker's cervical spine range of motion of flexion, extension, lateral rotation, lateral bending was at 100%; bilateral shoulder range of motion was abduction 170 degrees, forward flexion 170 degrees, internal rotation 80 degrees, external rotation 60 degrees, and extension 30 degrees. Impingement and apprehension signs were negative. The injured worker's range of motion of the elbows bilaterally was 135 of flexion, 0 degrees of extension, 85 degrees of supination, and 85 degrees of pronation. The range of motion of the injured worker's wrists bilaterally was 75 degrees of dorsiflexion, 75 degrees of palmar flexion, 85 degrees of supination, 85 degrees of pronation, 20 degrees of radial deviation, and 40 degrees of ulnar deviation. The Tinel's sign and Phalen's tests were both negative bilaterally. The injured worker had mild decreased sensation of the median nerve distribution bilaterally. Medications included Norco. The treatment plan included the physician's recommendation for the injured worker to continue awaiting surgery and to followup in 6 months. The rationale and Request for Authorization form were not provided within the medical records received.

IMR ISSUES, DECISIONS AND RATIONALES

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

Post operative Q-tech cold therapy recovery system with wrap, QTY: 35 day rental:

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment in Workers Compensation (TWC): Shoulder Procedure Summary last updated 07/29/2014

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute & Chronic), Continuous-flow cryotherapy

Decision rationale: The request for postoperative Q tech cold therapy recover system with wrap, quantity: 35 day refill is not medically necessary. The injured worker had complaints of constant severe cervical spine pain, constant severe pulsating sensations of the shoulders bilaterally, and complaints of constant severe pain to the hands and wrists bilaterally. The California MTUS/ACOEM Guidelines do not address. The Official Disability Guidelines recommend continuous-flow cryotherapy as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries such as muscle strains and contusions has not been fully evaluated. It is noted the injured worker has previously been approved for a 7 day use with continuous-flow cryotherapy. The guidelines state postoperatively Continuous-flow cryotherapy use generally may be up to 7 days, including home use. However, the request for 35 day rental exceeds the recommended 7 day guideline. As such, the request is not medically necessary.

Pro-stim 5.0 with supplies, QTY: 30 day rental: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tens, Chronic Pain (Transcutaneous Electrical Nerve Stimulation). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment in Workers Compensation (TWC): Shoulder Procedure Summary last updated 07/29/2014

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-116. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute & Chronic), TENS (transcutaneous electrical nerve stimulation).

Decision rationale: The request for Pro stim 5.0 with supplies, quantity: 30 day rental is not medically necessary. The injured worker had complaints of constant severe cervical spine pain, constant severe pulsating sensations of the shoulders bilaterally, and complaints of constant severe pain to the hands and wrists bilaterally. The California MTUS Guidelines indicate transcutaneous electrical nerve stimulation is not recommended as a primary treatment modality,

but a 1 month home based TENS trial may be considered as a noninvasive conservative option, if used in adjunct to a program of evidence based functional restoration. A home based trial of 1 month may be appropriate for neuropathic pain, CRPS II and for CRPS I. The Official Disability Guidelines recommend the use of a TENS unit poststroke to improve passive humeral lateral rotation, but there is limited evidence to determine if the treatment improves pain. For other shoulder conditions, TENS units are not supported by high quality medical studies, but they may be useful in the initial conservative treatment of acute shoulder symptoms. There is a lack of documentation that the injured worker was executing a program of evidence based functional restoration to be used as an adjunct with the use of a TENS unit. Furthermore, the injured worker is noted to be awaiting shoulder surgery for which the Guidelines do not indicate the use of a TENS unit. Additionally, the injured worker is noted to have been approved for a continuous-flow cryotherapy unit postsurgically, the need for multiple modalities for postoperative pain management is not indicated. As such, the request is not medically necessary.

Pro-stim 5.0 with supplies, purchase if effective: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tens, Chronic Pain (Transcutaneous Electrical Nerve Stimulation). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment in Workers Compensation (TWC): Shoulder Procedure Summary last updated 07/29/2014

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

Decision rationale: As the primary request is not medically necessary, the associated service is also not medically necessary.