

Case Number:	CM13-0046736		
Date Assigned:	12/27/2013	Date of Injury:	01/21/2002
Decision Date:	02/04/2015	UR Denial Date:	09/27/2013
Priority:	Standard	Application Received:	11/01/2013

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 in Physical Medicine Rehab, has a subspecialty in Interventional spine, and is licensed to practice in California. 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 patient is a 49 year old female with the injury date of 1/21/02. Per physician's report 10/25/13, the patient has pain in his neck, shoulders and upper extremities bilaterally at 9/10. The patient has difficulty falling and staying asleep due to numbness and tingling in her hands. Her shoulder range of motion is limited bilaterally. Tinel's test is positive on the right side. The patient is unable to perform simple activities such as brushing her teeth or hair. The patient had Stellate ganglion block injections, which gave her 50-60% improvement. The diagnosis is s/p right shoulder arthroscopy with residual complex regional pain syndrome of the right upper extremity. The patient will return back to work in 4 to 6 weeks. Per 08/06/13 progress report, the patient's right shoulder has been improved with 6 sessions of physical therapy. Per 09/04/13 report, the patient has neck pain at 8-9/10, radiating to shoulders, right greater than left and lower back pain. The patient underwent right shoulder scope/SAD/Mumford/SLAP repair on 02/08/12. The utilization review on 09/27/13 partially certified 6 sessions of physical therapy and one Stellate ganglion block. The utilization review determination being challenged is dated on 09/27/13. Treatment reports were provided from 06/13/13 to 12/18/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-99.

Decision rationale: The patient presents with pain and weakness in her neck, shoulders and arms bilaterally. The patient is s/p right shoulder scope/SAD/Mumford/SLAP repair on 02/08/12. The request is for physical therapy. The current request of physical therapy appears outside of post-surgical time frame. For non-post-operative therapy treatments, MTUS guidelines page 98 and 99 allow 8-10 sessions for neuralgia, neuritis, and radiculitis, unspecified and 9-10 sessions for myalgia and myositis, unspecified. The 08/06/13 progress report indicates that the patient has had at least 6 sessions of physical therapy in the past. Two physical therapy reports are provided on 02/04/13 and 08/08/13. None of the reports discuss how many sessions of therapy the patient has had in the past and what can be accomplished with additional therapy. It would appear that the patient has had adequate therapy. The treater does not explain why the patient is unable to transition into a home program. The utilization review on 09/27/13 partially certified 6 sessions of physical therapy "to be utilized in conjunction with the Stellate ganglion block." Furthermore, the treater does not specify the amount of physical therapy. The request is not medically necessary.

Orthostim 4 unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular electrical stimulation (NMES devices) Page(s): 121.

Decision rationale: The patient presents with pain and weakness in her neck, shoulders and arms bilaterally. The patient is s/p right shoulder scope/SAD/Mumford/SLAP repair on 02/08/12. The request is for Orthostim 4 unit. MTUS Chronic Pain Medical Guidelines, pages 114-121, state that neuromuscular electrical stimulation devices such as OrthoStim are "Not recommended. NMES is used primarily as part of a rehabilitation program following stroke and there is no evidence to support its use in chronic pain. There are no intervention trials suggesting benefit from NMES for chronic pain." For Interferential Current Stimulation (ICS), MTUS guidelines state that "Not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone." These devices are recommended in cases where (1) Pain is ineffectively controlled due to diminished effectiveness of medications; or (2) Pain is ineffectively controlled with medications due to side effects; or (3) History of substance abuse; or (4) Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or (5) Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). In this case, the patient had at least 6 sessions of physical therapy and injections with improvement. It appears the patient has been responsive to conservative measures. It is not evident that conservative measures have failed. The treater has not discussed Orthostim or reason for the request. Per the utilization review letter 09/27/13, "The claimant was grateful for the OS4 unit

replacement." Since the patient was provided with the unit already, there should have been documentation of pain and functional improvement but this is not found in any reports. There is no discussion why another unit is being requested at this time. The request is not medically necessary.