

Case Number:	CM13-0009307		
Date Assigned:	09/19/2013	Date of Injury:	11/30/2000
Decision Date:	01/13/2014	UR Denial Date:	07/31/2013
Priority:	Standard	Application Received:	08/12/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery, has a subspecialty in Shoulder & Elbow Surgery 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 physician 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.

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 59-year-old male who reported an injury on 11/30/200. The mechanism of injury was not provided in the medical records. The patient is reported to have a past history of a cervical fusion on 04/30/2007 and to have undergone 2 right shoulder surgeries, the first on 01/24/2002, and the second in 07/30/2002. He is reported to have been diagnosed with cervical spine fusion (04/30/2007) (799.9), thoracic spine strain 847.1, probable right shoulder internal derangement, status post right shoulder surgery x2, right shoulder strain, and right carpal tunnel syndrome. The patient is noted to have previously treated with ESWT to the right shoulder in late 01/2013 and early 02/2013. The clinical note dated 05/28/2013 signed by ██████ noted the patient complained of neck and thoracic pain, bilateral shoulder pain, and right wrist and hand pain. He was reported on physical exam to have decreased range of motion of the cervical spine in all planes, 5/5 muscle strength of the bilateral upper extremities, and intact sensation to the bilateral upper extremities. The patient was noted to have undergone a radiofrequency ablation of the cervical spine on 04/17/2013. A clinical note dated 07/09/2013 signed by ██████ reported the patient continued to have decreased range of motion of the lumbar spine. He had 5/5 strength of the left lower extremity and sensation of the left lower extremity was reported to be intact. At that time, a request was submitted for a Combo Care 4 stimulator and a contrast compression pad. The patient was noted to have been prescribed Prilosec 20 mg.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prilosec 20mg, #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 69.

Decision rationale: The patient is a 59-year-old male who reported an injury on 11/30/2000. He is reported to complain of ongoing neck, mid and upper back pain, bilateral shoulder pain, and right wrist and hand pain. He is noted to have previously undergone a cervical fusion in 2007 at unstated levels and 2 right shoulder surgeries. He is noted on physical exam to have decreased range of motion of the cervical and lumbar spine, 5/5 strength of the bilateral upper and lower extremities, and intact sensation of the bilateral upper and lower extremities. A prescription for Prilosec was given. The California MTUS Guidelines recommend the use of an H2 receptor antagonist or a PPI for treatment of dyspepsia secondary to NSAID therapy. As the patient is not noted to be taking an NSAID and there is no documentation that the patient complains of GI upset, the requested Prilosec does not meet guideline recommendations. Based on the above, the request for Prilosec 20mg is neither medically necessary nor appropriate.

Combo core stimulation 4 unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy.

Decision rationale: The combo core stimulation 4 unit is not indicated. The patient is a 59-year-old male who reported an injury on 11/30/2000. He is noted to have a past history of a cervical fusion on 04/30/2007 and to have undergone 2 right shoulder surgeries, the first on 01/24/2002, and the second in 07/30/2002. He is noted to continue to complain of neck pain, mid and lower back pain, right and left shoulder pain, and right wrist pain. He is reported to have treated conservatively with radiofrequency ablation of the cervical spine and ESWT treatments to the right shoulder. A request was made for a ComboCare stimulator unit. The California MTUS Guidelines recommend the use of a TENS unit after a 1 month trial with documentation that all other appropriate pain modalities have been tried and failed. The California MTUS Guidelines do not recommend the use of an interferential unit as an isolated intervention as there is no quality evidence of effectiveness, except for in conjunction with recommended treatments such as return to work exercise and medications, and there is limited evidence of improvement with the use of an interferential stimulator with those recommended treatments alone. The California MTUS Guidelines do not recommend the use of a neuromuscular stimulator, except for use as part of a rehabilitation program following a stroke, for treatment of spinal cord injuries, and also to stimulate the quadriceps muscles following a major knee surgery. As the patient is not noted to have a trial of the unit and is not reported to be performing a home exercise program or attending physical therapy, and is not diagnosed with a stroke, a spinal cord injury, or to have undergone a major knee surgery, the requested combo core stimulation 4 unit does not meet

guideline recommendations. Based on the above, the requested combo core stimulation 4 unit is not medically necessary or appropriate.

Contrast compression pad: 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), Treatment Index, 11th Edition (web), 2013, Knee and Leg-Game Ready..

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Online Version, and Knee & Leg (Acute & Chronic) Chapter. Game Readyâ€¢ accelerated recovery system..

Decision rationale: The patient is a 59-year-old male who reported an injury on 11/30/2000. He is reported to be status post cervical fusion and 2 right shoulder surgeries. He is reported to continue to complain of ongoing neck, upper and mid back pain, bilateral shoulder pain, and right wrist and hand pain. On physical exam, the patient is noted to have decreased range of motion of the cervical spine, and 5/5 strength of the bilateral upper and lower extremities with intact sensation to the bilateral upper and lower extremities. A request was made for a contrast compression pad. The California MTUS/ACOEM does not address the request. The Official Disability Guidelines state, while there are studies on continuous flow cryotherapy, there are no published high-quality studies on game ready devices or any other combined systems. As there is no indication of where the contrast compression unit is to be used, and the guidelines do not recommend a combined unit consisting of hot and cold contrast along with compression, the requested contrast compression pad does not meet guideline recommendations and is not medically necessary or appropriate.