

Case Number:	CM13-0014424		
Date Assigned:	01/03/2014	Date of Injury:	07/31/2012
Decision Date:	03/11/2014	UR Denial Date:	07/25/2013
Priority:	Standard	Application Received:	08/21/2013

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 Physical Medicine & Rehabilitation 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. 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:

This female sustained an injury on 7/31/12 while employed by [REDACTED]. Requests under consideration include Left Shoulder Injection, TENS unit & supplies (rental or purchase), and Cervical Pillow. Report of 7/16/13 from [REDACTED] noted patient with neck, left upper back, left shoulder radiating to left arm and lower back pain. Previous treatment has included physical therapy, 12 sessions of acupuncture, chiropractic therapy and massage therapy providing good relief for few hours after sessions. Medications include ASA, Flexeril, Ibuprofen, Levothyroxine, and Tylenol ES. Exam showed cervical spine with limited range; spasm; trigger point on left side; spinous process tenderness at C6 and C7 and trapezius and paracervical muscles; Spurling's causes neck pain radiating to upper extremity; left shoulder with restrictive range; positive Hawkins/ Neer; 5-/5 muscle strength in left shoulder; decreased sensation over hand and forearm. Treatment included above with pain psychology referral, EMG/NCV, lab work; and modified duty of 5 pound limitation. Above requests were non-certified on 7/25/13 citing guidelines criteria and lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Shoulder Injection: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 213. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) -TWC Shoulder procedure summary.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204.

Decision rationale: The Physician Reviewer's decision rationale: This female sustained an injury on 7/31/12 while employed by [REDACTED]. Requests under consideration include Left Shoulder Injection, TENS unit & supplies (rental or purchase), and Cervical Pillow. Report of 7/16/13 from [REDACTED] noted patient with neck, left shoulder and lower back pain. Previous treatment has included physical therapy, 12 sessions of acupuncture, chiropractic therapy and massage therapy providing good relief for few hours after sessions. Medications include ASA, Flexeril, Ibuprofen, Levothyroxine, and Tylenol ES. Exams of the cervical spine and left shoulder showed restricted range, tenderness, and positive provocative testing with 5-/5 motor strength and diffuse sensory loss without dermatomal pattern. Treatment included shoulder injection, TENS unit, cervical pillow, MRIs, psychology referral, EMG/NCV, lab work; and modified duty of 5 pound limitation. There is no specific failed conservative treatment noted to meet criteria of corticosteroid injection nor has there been clear documented functional improvement by way of ADLs or decrease in medication dosing or medical utilization to support current request. Guidelines states if pain with elevation is significantly limiting activities, a subacromial injection of local anesthetic and a corticosteroid preparation may be indicated after conservative therapy (i.e., strengthening exercises and NSAIDs) for two to three weeks, but the evidence is not yet overwhelming, and the total number of injections should be limited to no more than three. Although injections into the subacromial space and acromioclavicular joint can be performed in the clinician's office, injections into the glenohumeral joint should only be performed under fluoroscopic guidance. A recent meta-analysis concluded that subacromial corticosteroid injection for rotator cuff disease and intra-articular injection for adhesive capsulitis may be beneficial although their effect may be small and not well maintained. Additionally, for post-traumatic impingement of the shoulder, subacromial injection of methylprednisolone had no beneficial impact on reducing the pain or the duration of immobility. Submitted reports have not specified limitations with activities or functional improvement from previous injection to support for this unspecified shoulder injection. The Left Shoulder Injection is not medically necessary and appropriate.

TENS unit & supplies (rental or purchase): 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): 114-118.

Decision rationale: The Physician Reviewer's decision rationale: Per MTUS Chronic Pain Treatment Guidelines, ongoing treatment is not advisable if there are no signs of objective progress and functional restoration has not been demonstrated. Specified criteria for the use of TENS Unit include trial in adjunction to ongoing treatment modalities within the functional restoration approach as appropriate for documented chronic intractable pain of at least three months duration with failed evidence of other appropriate pain modalities tried such as

medication. It appears the patient has received extensive conservative treatment to include medications, multiple therapy modalities and injections; however, functional status and pain relief remain unchanged. There is no documented short-term or long-term goals of treatment with the TENS unit. Submitted reports have not adequately addressed or demonstrated any functional benefit or pain relief as part of the functional restoration approach to support the request for the Home TENS Unit. There is no evidence for change in work status, increased in ADLs, decreased VAS score, medication usage, or treatment utilization from the physical therapy treatment already rendered. The TENS unit& supplies (rental or purchase) is not medically necessary and appropriate.

Cervical Pillow: 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)-TWC Neck & Upper Back Procedure Summary.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pillow, page 626 and <http://www.aetna.com/cpb/medical> Clinical Policy Bulletin: Pillows and Cushions, Number: 0456 Policy.

Decision rationale: The Physician Reviewer's decision rationale: Although MTUS, ACOEM Guidelines do not specifically address or have recommendations for this DME, other guidelines such as ODG and Aetna's contractual definition of durable medical equipment (DME) in that they are not durable and because they are not primarily medical in nature and not mainly used in the treatment of disease or injury. It further states "Cushions may be covered if it is an integral part of, or a medically necessary accessory to, covered DME" such as seat cushions for required wheelchairs in prevention of decubiti. Regarding sleeping pillows (ergonomic pillows, orthopedic pillows, orthopedic foam wedges) (e.g., Accu-Back Ergonomic Sleeping Pillow, Core Pillow, Mediflow Waterbase Pillow), a number of specialized pillows and cushions have been used for cushioning and positioning in the treatment of decubiti, burns, musculoskeletal injuries and other medical conditions. Aetna does not generally cover pillows and cushions, regardless of medical necessity, because they do not meet Aetna's definition of covered durable medical equipment, in that pillows and cushions are not made to withstand prolonged use. In addition, most pillows and cushions are not primarily medical in nature, and are normally of use to persons who do not have a disease or injury. ODG states the cervical pillow may be appropriate in conjunction with daily exercise and should be treated by health professionals trained to teach both exercises and the appropriate use of a neck support pillow during sleep as either strategy alone did not give the desired clinical benefit. Submitted reports have not demonstrated support for this DME per above references. The Cervical Pillow is not medically necessary and appropriate.