

Case Number:	CM13-0044333		
Date Assigned:	12/27/2013	Date of Injury:	04/30/2013
Decision Date:	06/09/2014	UR Denial Date:	10/23/2013
Priority:	Standard	Application Received:	10/29/2013

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 General Surgery, has a subspecialty in Hand and Upper Extremity Surgery and is licensed to practice in Texas. 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 59 year old female who sustained an injury on 04/30/13. The patient had no specific mechanism of injury. This appeared to be a repetitive use issue for the right shoulder and right wrist as the first report of occupational injury or illness indicated that her symptoms started in 2012 and had become progressively worse. The patient was initially seen for physical therapy in May of 2013. The patient continued physical therapy through 05/28/13. Electrodiagnostic studies from 06/27/13 were negative for any pertinent findings. The patient was seen on 07/02/13 for persistent complaints of right elbow pain that was increased with activities. The patient did report benefits from physical therapy to the left upper extremity. On physical examination, there was continued tenderness to palpation in the right elbow over the lateral and medial epicondyles. The patient also exhibited tenderness to palpation over the paravertebral musculature in the cervical spine and at the trapezius. Spurling's sign caused neck pain only. There was loss of cervical range of motion. The agreed medical evaluation from [REDACTED] on 07/16/13 did recommend the patient for ultrasound and MRI studies to ascertain the presence of pathology. MRI studies of the cervical spine from 07/17/13 noted some abnormal signal at T2. There was disc bulging without foraminal stenosis present. Follow up on 08/12/13 noted continuing complaints of pain in the bilateral elbows with associated numbness and tingling with carrying. Medications at this visit included Ultram 50mg used daily. There continued to be tenderness to palpation in the bilateral medial and lateral epicondyles with a positive Cozen's sign. There was also tenderness at the right wrist over the distal flexor and extensor tendons as well as over the 1st dorsal compartment. Finkelstein's sign was positive. Ultrasound studies were requested at this evaluation and Ultram was refilled. The patient was also recommended for further chiropractic therapy and requested for a wrist splint. Ultrasound of the bilateral elbows did note edema and thickening of the common extensor and flexor

tendons at the right elbow. There were also inflammatory changes noted at the common extensor tendon origin of the left elbow. The updated agreed medical evaluation from 08/27/13 indicated the patient was not interested in further invasive treatment. The patient was felt to have reached a plateau of therapy and was considered permanent and stationary. The patient was given a 6% whole person impairment. The patient was referred for chiropractic manipulation in August of 2013. Follow up on 09/24/13 indicated the patient had 2 sessions out of 6 authorized chiropractic therapy sessions with slight improvement in regards to range of motion and decreased pain in the elbows. The patient was continuing to utilize Ultram 3 times per week which was reducing pain down to 5/10 on the VAS from 8. The patient was able to perform more activities of daily living with this medication. On physical examination, there was slightly decreased tenderness to palpation in the cervical spine and paravertebral musculature as well as the trapezius. There continued to be some loss of range of motion in the cervical spine. Urine drug screens from 09/27/13 noted positive results for Tramadol.

IMR ISSUES, DECISIONS AND RATIONALES

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

ADDITIONAL CHIROPRACTIC MANIPULATION QTY: 8.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Section Page(s): 58-60.

Decision rationale: In regards to additional chiropractic manipulation for 8 sessions, this reviewer would not have recommended this therapy as medically necessary. From the clinical documentation submitted, the patient had attended 2 sessions of an authorized 6 of chiropractic therapy with some reported improvements. The overall result from the initial 6 sessions of chiropractic therapy was not specifically documented. The clinical documentation submitted for review did not provide any clear objective findings for exceptional factors in the neck or the upper extremities that would have reasonably benefitted from further chiropractic manipulation. Therefore, this reviewer would not have recommended this continued therapy as medically necessary.

HOME TENS UNIT: Upheld

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

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

Decision rationale: In regards to the use of a home TENS unit, this reviewer would not have recommended this durable medical equipment as medically necessary. There was no clinical documentation indicating that the patient had any substantial functional improvement with the

use of a TENS unit that resulted in decreased pain medication usage, decreased subjective pain, or increased functional ability that would warrant its continuing use. Therefore, this reviewer would not have recommended this durable medical equipment as medically necessary.

██████████(MOIST HEAT 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).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) FOREARM, WRIST, & HAND CHAPTER, HEAT THERAPY SECTION.

Decision rationale: In regards to a ██████████ heating pad, this reviewer would not have recommended this durable medical equipment as medically necessary. There is no indication from the clinical literature that heating pads result in any substantial functional improvement in regards to chronic neck or upper extremity pain. The clinical records did not indicate that the patient had any substantial functional improvement with the use of this modality that would have supported continuation of this type of therapy. Therefore, this reviewer would not have recommended this durable medical equipment as medically necessary.

ULTRAM 50 MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 88-89.

Decision rationale: In regards to the continued use of Ultram 50mg, this reviewer would have recommended this medication as medically necessary. The patient was utilizing 50mg Ultram 2-3 times per week with significant reduction in pain and improvement in functional ability. Given the benefits obtained with a minimal amount of Ultram, this reviewer would have recommended this medication for continued use.

RETROSPECTIVE REQUEST FOR RANDOM URINE SAMPLE DOS 9/24/13: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) PAIN CHAPTER, URINE DRUG SCREEN TESTING SECTION.

Decision rationale: In regards to the retrospective urinary drug screen from 09/24/13, this reviewer would have recommended this test as medically necessary. The patient had been

utilizing Tramadol for an extended period of time. A urinary drug screen to check for compliance would be considered standard of care and reasonably necessary. Per guidelines, the use of urinary drug screen testing is appropriate on a random basis of at least once per year to ensure compliance with prescribed controlled substances. Therefore, this reviewer would have recommended this test as medically necessary.