

Case Number:	CM13-0049352		
Date Assigned:	12/27/2013	Date of Injury:	09/22/1987
Decision Date:	08/26/2014	UR Denial Date:	10/30/2013
Priority:	Standard	Application Received:	11/08/2013

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 Internal Medicine 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:

Patient is a 62-year-old male who has submitted a claim for lumbosacral neuritis, bilateral knees internal damage, cervical sprain, lumbar strain, and bilateral shoulder tendinitis associated with an industrial injury date of 09/22/1987. Medical records from 2013 were reviewed. Patient complained of minimal right shoulder pain status post reverse total shoulder arthroplasty. He denied numbness and tingling sensation. Physical examination of the right shoulder showed tenderness, ecchymosis and pain upon abduction towards 20 degrees. Shoulder internal and external rotation was limited. Edema was noted in bilateral lower extremities. Treatment to date has included reverse total shoulder arthroplasty on 09/23/2013, home exercise program, physical therapy, and medications such as Percocet and Lyrica. Utilization review from 10/30/2013 denied the request for Polar ice machine (rental for additional six months) for pain and swelling control because of lack of subjective complaints and clinical findings to support the request; denied shower bench, three-way portable toilet, and foot orthotics to improve gait because there were no findings pertaining to the lower extremities; denied neurological consultation for insight into neuropharmacology of chronic pain because patient only presented with two months of right shoulder pain; denied Percocet because of no explanation for the need of both oxycodone and Percocet; and denied Lyrica because of lack of documented rationale for its use.

IMR ISSUES, DECISIONS AND RATIONALES

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

Polar ice machine for six (6) months: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Aetna Clinical Policy Bulletin: Cryoanalgesia and Therapeutic Cold.

Decision rationale: CA MTUS does not specifically address cold therapy units. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation the Aetna Clinical Policy Bulletin was used instead. Aetna considers the use of hot/ice machines and similar devices experimental and investigational for reducing pain and swelling after surgery or injury. Studies failed to show that these devices offer any benefit over standard cryotherapy with ice bags/packs. In this case, patient underwent reverse total right shoulder arthroplasty on 09/23/2013. The use of polar ice machine became useful for control of pain and swelling. However, there was no discussion regarding the indication for a polar ice machine despite it being experimental and investigational. Guidelines do not recommend the use of this device. It is unclear due to lack of discussion why regular cold packs cannot suffice. Therefore, the request for polar ice machine x 6 months is not medically necessary.

Shower bench: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg Section, Durable Medical Equipment.

Decision rationale: The CA MTUS does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, the Official Disability Guidelines (ODG), Knee and Leg Section was used instead. It states that durable medical equipment (DME) is recommended generally if there is a medical need or purpose, is appropriate for home use, is generally not useful to a person in the absence of illness, and can withstand repeated use. Most bathroom and toilet supplies do not customarily serve a medical purpose and is primarily used for convenience in the home. Environmental modifications are considered not primarily medical in nature. In this case, a shower bench is being requested to reduce fall risk because patient had difficulty unhooking his shoulder harness and shoulder sling being in a post-operative state. However, it is considered a self-help device, and not primarily medical in nature. The guideline criteria for durable medical equipment have not been met. Therefore, the request for shower bench is not medically necessary.

3-way portable toilet: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg Section, Durable Medical Equipment.

Decision rationale: The CA MTUS does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, the Official Disability Guidelines (ODG), Knee and Leg Section was used instead. It states that durable medical equipment (DME) is recommended generally if there is a medical need or purpose, is appropriate for home use, is generally not useful to a person in the absence of illness, and can withstand repeated use. Most bathroom and toilet supplies do not customarily serve a medical purpose and is primarily used for convenience in the home. Environmental modifications are considered not primarily medical in nature. In this case, a portable toilet is requested to be placed beside patient's bed for easier access. However, it is considered a self-help device, and not primarily medical in nature. The guideline criteria for durable medical equipment have not been met. Therefore, the request for three-way portable toilet is not medically necessary.

Foot orthotist referral: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine, 2nd edition: Chapter 7; Independent Consultations, page 127.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7, Independent Medical Examinations and Consultations, page 127.

Decision rationale: As stated on page 127 of the California MTUS ACOEM Independent Medical Examinations and Consultations Chapter, occupational health practitioners may refer to other specialists if the diagnosis is uncertain, or when psychosocial factors are present. In this case, a foot orthotist referral is requested to improve patient's gait. However, there were no subjective complaints or objective findings presented to warrant this request. The medical necessity cannot be established due to insufficient information. Therefore, the request for foot orthotist referral is not medically necessary.

Neurology consult: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine, 2nd edition: Chapter 7; Independent Consultations, page 127.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7, Independent Medical Examinations and Consultations, page 127.

Decision rationale: As stated on page 127 of the California MTUS ACOEM Independent Medical Examinations and Consultations Chapter, occupational health practitioners may refer to other specialists if the diagnosis is uncertain, or when psychosocial factors are present. In this case, a neurology referral is requested for insight into neuropharmacology of chronic pain. However, the medical records did not reveal uncertainty or complexity of issues on pain management. Furthermore, there was no indication of failure of current therapies for the patient's pain problems, which may warrant a referral to a pain management specialist. There is no clear rationale for the requested service. Therefore, the request for neurology consult is not medically necessary.

Percocet: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

Decision rationale: As stated on page 78 of CA MTUS Chronic Pain Medical Treatment Guidelines, there are 4 A's for ongoing monitoring of opioid use: pain relief, side effects, physical and psychosocial functioning and the occurrence of any potentially aberrant drug-related behaviors. The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. In this case, patient has been on Percocet since October 2013. However, the medical records do not clearly reflect continued analgesia, continued functional benefit, or a lack of adverse side effects. MTUS Guidelines require clear and concise documentation for ongoing management. Therefore, the request for Percocet is not medically necessary.

Lyrica: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs Page(s): 16-17.

Decision rationale: As stated on pages 16 - 17 of CA MTUS Chronic Pain Medical Treatment Guidelines, antidepressants, such as pregabalin and gabapentin, are recommended as a first line option for neuropathic pain, i.e., painful polyneuropathy. In this case, the patient has been on Lyrica since October 2013 for lumbosacral neuritis. However, there was no documentation concerning pain relief and functional improvement derived from its use. Moreover, the request

failed to specify dosage and quantity to be dispensed. Therefore, the request for Lyrica is not medically necessary.