

Case Number:	CM13-0057874		
Date Assigned:	12/30/2013	Date of Injury:	08/18/2008
Decision Date:	04/14/2014	UR Denial Date:	11/22/2013
Priority:	Standard	Application Received:	11/25/2013

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 & Rehabilitation and is licensed to practice in Illinois. 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 63-year-old female who reported an injury on 08/18/2008 due to cumulative trauma while performing normal job duties. The patient reportedly sustained an injury to her right upper extremity and cervical spine. The patient's most recent clinical evaluation documented the patient was status post right shoulder arthroscopy in 04/2013. It was noted the patient completed 24 sessions of physical therapy with residual pain and limited range of motion. The patient's medications were listed as Norco, Soma, gabapentin, and naproxen. The patient's physical findings included limited shoulder range of motion described as 90 degrees in abduction, 110 degrees in flexion, and 4/5 strength in abduction and flexion. The patient had a positive Tinel's sign bilaterally with tenderness to palpation along the carpal tunnel bilaterally. The patient had restricted cervical range of motion with tenderness to palpation along the cervical paraspinal musculature. The patient's diagnoses included discogenic cervical condition, rotator cuff tear status post decompression, and depression, stress, and sleep disorder. The patient's treatment plan included continuation of medications, continuation of physical therapy, the use of a TENS unit, cervical pillow, and hot/cold wrap.

IMR ISSUES, DECISIONS AND RATIONALES

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

CHIROPRACTIC SESSIONS (CERVICAL/SHOULDER): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58.

Decision rationale: The requested chiropractic sessions for the cervical and shoulder are not medically necessary or appropriate. California Medical Treatment Utilization Schedule does recommend the use of manual manipulation for chronic neck and shoulder pain. However, the request as it is written does not clearly identify duration of treatment. Therefore, the appropriateness of this treatment request is not established. As such, the requested chiropractic sessions (cervical/shoulder) is not medically necessary or appropriate.

HOT/COLD WRAP: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173-174.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181-183.

Decision rationale: The requested hot/cold wrap is not medically necessary or appropriate. American College of Occupational and Environmental Medicine does recommend applications of heat and cold for management of chronic pain. However, the clinical documentation fails to provide any evidence that the patient has not responded to lower levels of self-managed, self-directed hot/cold applications and requires the addition of a hot/cold wrap. As such, the requested hot/cold wrap is not medically necessary or 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 and Upper Back.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back, Pillow.

Decision rationale: The requested cervical pillow is not medically necessary or appropriate. Official Disability Guidelines recommend cervical pillow for support during sleep in conjunction with daily active therapy. The clinical documentation submitted for review does provide evidence that the patient is in physical therapy. However, it is not clearly described the patient is participating in a daily home exercise program that would benefit from an adjunct therapy such as a cervical pillow. As such, the requested cervical pillow is not medically necessary or appropriate.

TENS UNIT AND 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 Page(s): 114.

Decision rationale: The requested TENS unit and supplies for rental or purchase is not or appropriate. California Medical Treatment Utilization Schedule does recommend the use of a TENS unit as an adjunct therapy to active therapy. The clinical documentation does indicate that the patient is participating in physical therapy. However, California Medical Treatment Utilization Schedule recommends the purchase of a TENS unit be based on a 30-day home trial that provides functional benefit of pain relief. The request as it is written does not clearly identify whether this unit is for rental or purchase. As there is no documentation the patient has undergone a trial of this treatment modality with functional benefits and pain relief, the purchase of this unit would not be supported. As such, the requested TENS unit and supplies (rental or purchase) is not medically necessary or appropriate.