

<b>Case Number:</b>	CM14-0002518		
<b>Date Assigned:</b>	01/29/2014	<b>Date of Injury:</b>	01/24/2004
<b>Decision Date:</b>	06/16/2014	<b>UR Denial Date:</b>	12/23/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/07/2014

### 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 injured worker is a 58 year old female who reported an injury on 04/20/2004 secondary to lifting. The clinical note dated 11/21/2013 reported the injured worker denied new medications, new accidents, injuries, illnesses, hospitalizations, or operations. The physical examination reported tenderness over the injured worker's shoulders bilaterally with a range of motion at 130 degrees abduction to her right shoulder and 150 degrees abduction to her left shoulder. The diagnoses included chronic strain/sprain of the cervical/thoracic spine, cervical discogenic disease, bilateral carpal tunnel syndrome, and left shoulder capsulitis with impingement syndrome. The injured worker had an MRI on 11/25/2005 with findings of a 1mm disc bulge at C3-5 and a 1.5mm disc bulge at C4-5 and C5-6. The injured worker was status post left shoulder decompression on 10/10/2007. The request for authorization was not submitted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **GYM MEMBERSHIP X 12 MONTHS:** 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), Shoulder, Gym Membership.

**Decision rationale:** The request for Gym Membership x 12 months is not medically necessary. The injured worker has a history of a work related injury to her bilateral shoulders, right upper/lower arm, and neck. The Official Disability Guidelines do not recommend gym membership as a medical prescription unless a home exercise program has not been effective. Plus, treatment needs to be monitored and administered by medical professionals. While an individual exercise program is of course recommended, more elaborate personal care where outcomes are not monitored by a health professional, such as gym memberships or advanced home exercise equipment, may not be covered under this guideline, although temporary transitional exercise programs may be appropriate for patients who need more supervision. The documentation submitted for review stated the injured worker's gym membership was helpful and allowed her to use less medication and experienced decreased pain in her neck and shoulders; however, the documentation failed to provide details regarding an ineffective home exercise program as well as any assessment or revision to the injured worker's exercise program or objective functional improvement. Therefore, the request for Gym Membership x 12 months is not medically necessary.

**ELECTRODES FOR TENS UNIT:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS, CHRONIC PAIN Page(s): 114-115.

**Decision rationale:** The request for Electrodes for TENS unit is not medically necessary. The injured worker has a history of a work related injury to her bilateral shoulders, right upper/lower arm, and neck. The CA MTUS does not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration. The clinical information, submitted for review, states the injured worker has been using a TENS unit; however, the documentation fails to provide a clear reason for the continued use of the unit and if it will be used in conjunction with other therapy or if there has been any objective functional improvement. In addition the area of use it is requested for is not provided. Furthermore, the request does not include the quantity of the electrodes requested. Therefore, the request for Electrodes for TENS unit is not medically necessary.

**OMEPRAZOLE 20 MG (REFILLS):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS,GI SYMPTOMS,CARDIOVASCULAR RISK.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI SYMPTOMS & CARDIOVASCULAR RISK Page(s): 68.

**Decision rationale:** The request for Omeprazole 20mg (refills) is not medically necessary. The injured worker has a history of a work related injury to her bilateral shoulders, right upper/lower arm, and neck. The CA MTUS Guidelines identifies that risk for gastrointestinal events includes patients age > 65 years; history of peptic ulcer, GI bleeding or perforation; concurrent use of ASA, corticosteroids, and/or an anticoagulant; and/or high dose/multiple NSAID. The Guidelines also state the requested medication is recommended for patients at risk for gastrointestinal events. Based on the clinical information, provided for review, there is a lack of documentation within the clinical notes, to show the injured worker has had any gastrointestinal events or is at risk for such. In addition, the provided request does not state the quantity of medication requested or the amount of refills. Therefore, the request for Omeprazole 20mg (refills) is not medically necessary.

**ZOLPIDEM 5 MG (REFILLS): 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 In Worker's Compensation ,Pain(Chronic).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Insomnia.

**Decision rationale:** The request for Zolpidem 5mg (refills) is not medically necessary. The injured worker has a history of a work related injury to her bilateral shoulders, right upper/lower arm, and neck. The Official Disability Guidelines recommend Zolpidem as a first-line medications for insomnia, additionally indicated for the short-term treatment of insomnia with difficulty of sleep onset (7-10 days). Ambien CR is indicated for treatment of insomnia with difficulty of sleep onset and/or sleep maintenance. The clinical information, provided for review, failed to provide clear evidence for the need of this medication. In addition, the provided request does not state the quantity of medication requested or the amount of refills. Therefore, the request for Zolpidem 5mg (refills) is not medically necessary.

**COMBO CARE 4 ELECTRO THERAPY TENS UNIT: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TRANSCUTANEOUS ELECTROTHERAPY Page(s): 114-116.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS, CHRONIC PAIN Page(s): 114-115.

**Decision rationale:** The request for Combo Care 4 Electro Therapy TENS Unit is not medically necessary. The injured worker has a history of a work related injury to her bilateral shoulders, right upper/lower arm, and neck. The CA MTUS does not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration. The clinical information, submitted for review, states the injured worker has been using a TENS unit; however, the documentation fails to provide a clear reason for the continued use of this unit

and if it will be used in conjunction with other therapy or if there has been any objective functional improvement. In addition the area of use it is requested for is not provided. Therefore, the request for Combo Care 4 Electro Therapy TENS Unit is not medically necessary.

**THERMOCOOL COMPRESSION SYSTEM WITH SUPPLIES:** 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 In Worker's Compensation.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Cold Packs.

**Decision rationale:** The request for Thermocool Compression system with supplies is not medically necessary. The injured worker has a history of a work related injury to her bilateral shoulders, right upper/lower arm, and neck. The Official Disability Guidelines do not recommend cryotherapy. However, the Official Disability Guidelines do recommend cold packs. Based on the clinical information, provided for review, it is unclear the length of use for this request as well the area of use it is requested for. Therefore, the request for Thermocool Compression system with supplies is not medically necessary.

**PHYSICAL THERAPY:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL THERAPY, Page(s): 98-99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL MEDICINE Page(s): 98-99.

**Decision rationale:** The request for physical therapy is not medically necessary. The injured worker has a history of a work related injury to her bilateral shoulders, right upper/lower arm, and neck. According to the CA MTUS guidelines, physical medicine may be recommended in the treatment of unspecified myalgia and myositis at 9-10 visits over 8 weeks in order to promote functional improvement. The clinical information, provided for review, failed to show evidence of current functional deficits. Therefore as the guidelines support 9-10 visits to promote functional improvement, in the absence of current functional deficits the request is not supported. In addition, there is no clear request to state the length of treatment. Therefore, this request is not medically necessary.