MAXIMUS Federal Services

Case Number:	CM14-0156605		
Date Assigned:	09/26/2014	Date of Injury:	05/06/2009
Decision Date:	12/10/2014	UR Denial Date:	09/12/2014
Priority:	Standard	Application Received:	09/24/2014

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 Family 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:

This is a 54-year-old female patient who reported an industrial injury to the right upper extremity on 5/6/2009, over 5 years ago, attributed to the performance of her usual and customary job duties when a stall door struck her while she was cleaning a bathroom. The patient has been treated for the diagnoses of right shoulder sprain, right lateral epicondylitis, right wrist sprain, and carpal tunnel syndrome to the right upper extremity. The patient complained of pain in the right shoulder, right elbow, and right wrist area. The patient also complained of weakness, numbness, and tingling that radiates into the hand. The objective findings on examination included "tenderness to palpation of the paracervical region, tenderness at the AC joint; tenderness at the subacromial space of the right shoulder; restricted range of motion of the right shoulder; impingement test positive; tenderness to palpation of the right elbow, tenderness to palpation of the right wrist; positive Tinel's sign on the right; positive Finkelstein's test on the right." The patient was being prescribed Norco; Gabapentin; Soma; Naproxen; Prilosec. The patient was noted to have had a urine toxicology screen on 7/23/2014 and 5/20/2013. The MRI the lumbar spine dated 6/17/2013, demonstrated anterior disc in osteophytes most pronounced at L2-L3 along with discogenic disease and minimal disc bulging with minimal narrowing of the spinal canal most pronounced at L3-L4 including bilateral neural foraminal encroachment. The MRI of the right wrist dated 6/17/2013, documented evidence of cystic changes most pronounced in the capitate, widening of the Luno-navicular joint, and a cluster assist ventral to the radial styloid consistent with the small cluster ganglion cysts The treatment plan included a right wrist splint; a urine toxicology screen; and a TENS unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Urine toxicology screen: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for chronic pain Page(s): 80-82. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter--drug testing; screening for addiction; Urine drug testing

Decision rationale: The patient has been ordered and provided a urine toxicology screen without any objective evidence to support medical necessity. The urine toxicology test was based on policy and not medical necessity. The qualitative urine drug screen was ordered as a baseline study based on office procedure for all patients without any objective evidence or rationale to support medical necessity. The screen is performed routinely without objective evidence to support medical necessity or rationale to establish the criteria recommended by evidence-based guidelines. The diagnoses for this patient do not support the use of opioids, as they are not recommended for the cited diagnoses or prescribed medicine for chronic back pain. There is no demonstrated medical necessity for a urine toxicology screen and it is not clear the provider ordered the urine toxicology screen based on the documented evaluation and examination for chronic pain. There was no rationale to support the medical necessity of a provided urine toxicology screen based on the documented objective findings. The patient should be on OTC medications as necessary.There is no demonstrated medical necessity for the provision of a urine drug screen for this patient based on the provided clinical documentation and the medications prescribed. There were no documented indicators or predictors of possible drug misuse in the medical documentation for this patient. There is no clear rationale to support the medical necessity of opioids. There was no indication of diversion, misuse, multiple prescribers, or use of illicit drugs. There is no provided clinical documentation to support the medical necessity of the requested future urine toxicology screen. There is no objective medical evidence to support the medical necessity of a comprehensive qualitative urine toxicology screen for this patient. The prescribed medications were not demonstrated to require a urine drug screen and there was no explanation or rationale by the requesting physician to establish medical necessity. The provider has requested a drug screen due without a rationale to support medical necessity other than to help with medication management. There was no patient data to demonstrate medical necessity or any objective evidence of cause. There is no provided rationale by the ordering physician to support the medial necessity of the requested urine drug screen in relation to the cited industrial injury, the current treatment plan, the prescribed medications, and reported symptoms. There is no documentation of patient behavior or analgesic misuse that would require evaluation with a urine toxicology or drug screen. There is no demonstrated medical necessity for the prescribed urine drug toxicology screen.

Right wrist splint: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) forearm, wrist, and hand chapter-splints; carpal tunnel syndrome chapter-physical therapy, brace

Decision rationale: The prescribed right wrist brace for the diagnosis of chronic right wrist sprain/strain and CTS over five (5) years after the date of injury not demonstrated to be medically necessary for the treatment of the effects of the industrial injury. The patient was reported to have right wrist pain; however, passive splinting was not recommended over rehabilitation exercises. There was no rationale supported with objective evidence to support the medical necessity of right wrist splint. There is no objective evidence provided to support the medical necessity of a wrist brace over five (5) years status post date of injury for the reported symptoms. The requesting physician failed to provide a rationale to support medical necessity of the requested right wrist splint for the cited diagnoses. The request is not medically necessary.

TENS unit for the right wrist/hand and low back: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300; 203,Chronic Pain Treatment Guidelines TENS unit chronic pain Page(s): 114-117. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) forearm, wrist, hand--TENS unit; Pain chapter--TENS unit

Decision rationale: The requesting provider did not provide subjective/objective evidence to support the medical necessity of the TENS Unit for the treatment of the back or wrist for more than the recommended 30-day trial rental The ACOEM Guidelines do not recommend the use of TENS Units for neck, shoulder, elbow, or wrist as there is no objective evidence available to support their use. There is no demonstrated medical necessity for a TENS unit is a freestanding treatment modality without the documentation of a functional restoration effort. It is recommended that the patient undergo a 30-day trial to demonstrate functional improvement prior to the purchase of a TENS unit for the treatment of the lumbar spine chronic pain issues. There is no justification for the use of the 4-lead TENS unit as required by the CA MTUS. The use of the TENS unit for the treatment for the wrist/hand/forearm/elbow/shoulder is not recommended by the CA MTUS or the ACOEM Guidelines. There is no objective evidence provided to support the medical necessity of the requested TENS Unit or electric muscle stimulator for the treatment of the back for the effects of the industrial injury. There was no documented functional improvement with use of a TENS unit in physical therapy; no documented 30-day trial rental; and no documented ongoing restoration program directed to the lower back. The TENS unit is directed to chronic back pain issues with a date of injury of over five years ago. The CA MTUS and the Official Disability Guidelines only recommends the use of the TENS unit for chronic lower back pain with a demonstrated exercise program for conditioning and strengthening. The TENS Unit is recommended for only chronic intractable pain. There was no provided documentation that the patient was participating in a self-directed

home exercise program. The ACOEM Guidelines revised back chapter 4/07/08 does recommend the use of the TENS Unit for the treatment of chronic lower back pain; however, it must be as an adjunct to a functional rehabilitation program and ongoing exercise program. The CA MTUS only recommend the use of the TENS unit for chronic lower back pain with a demonstrated exercise program for conditioning and strengthening. There are no recommendations for the use of the TENS Unit in the treatment of the back for acute pain. There is no recommendation for the use of TENS units for the knee. There was no rationale supported with objective evidence by the requesting physician to support the medical necessity of the purchase/rental of a TENS unit with supplies. There is no objective evidence provided by the requesting provider that the same results cannot be achieved with a home exercise program established for functional rehabilitation with strengthening and conditioning directed to the back and wrist. There is no demonstrated medical necessity for the purchase of a TENS for the rehabilitation of the chronic pain to the lower back and knee without an initial 30-day trial to demonstrate evidence of functional improvement.