MAXIMUS Federal Services

Case Number:	CM14-0058872		
Date Assigned:	08/08/2014	Date of Injury:	11/27/2013
Decision Date:	10/01/2014	UR Denial Date:	04/21/2014
Priority:	Standard	Application Received:	04/29/2014

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 Preventive Medicine 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 injured worker is a 61 year old male who was injured on 11/27/2013. The injured worker complains of pain in the neck, right shoulder, right arm, right hand and right wrist. On physical examination, the injured worker was found to have tenderness in the thorax, right shoulder, right hand and right elbow. There was limitation of movement in the right shoulder, positive O'Brien's test in the right shoulder. Right Shoulder MRI from 12/09/2013 revealed full thickness tear of long head of biceps, with distal retraction to the lower margin of bicipital groove; fraying/tearing of along the base of the superior labrum; small glenohumeral effusion; moderate tendinosis of the subscapularis tendon with mild interstitial tearing, and moderate tendinosis of the supraspinatus tendon with minimal fraying along the bursal surface; mild degenerative/ hypertrophic changes of the acromioclavicular joint. MRI of right elbow dated 12/09/2013 revealed mild strain, minimal tendinosis of the common extensor tendon. The injured worker has been diagnosed with superior glenoid labrum lesion; lumbar sprain and strain; and sprains and strains unspecified site, shoulder and upper arm. Treatment includes physical therapy, chiropractic care, Tramadol, Ibuprofen, compound medications, and a pain management referral. At dispute are the requests for Interspec Interferential Unit II, Monthly supplies; cold therapy unit, hot/cold pad; assay strap; functional capacity evaluation; urine drug screen; chiropractic/physiotherapy 3 times a week for 4 weeks; and topical compound cream, made on 03/31/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Functional Capacity Evaluation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM,Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines - Fitness for Duty

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Fitness for Duty, Functional Capacity Evaluation

Decision rationale: The medical records provided for review do not indicate a medical necessity for Functional Capacity Evaluation. The Official Disability Guidelines recommends that Functional Capacity Evaluation be done when the individual is nearing maximum medical improvement; if the worker is actively participating in determining the suitability of a particular job. Additionally, the Official Disability Guidelines recommends that as much detail as possible be provided about the specifics of the job. Furthermore, FCE is recommended when there have been prior unsuccessful attempts at return to work, or when there is conflicting medical reporting on precautions and/ or fitness for modified job. The documents reviewed did not provide specific indication(s) for the Functional Capacity Evaluation. Therefore, this request is not medically necessary.

Urine drug screen: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM,Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines - Fitness for Duty

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

Decision rationale: The medical records provided for review do not indicate a medical necessity for Urine drug screen. Although the medical records indicates the injured worker has been on treatment with Tramadol, an opioid, the records failed did not provide information on the risk stratification which will help in determining how often this test will be done, how long the injured worker has been on the medication, the last time urine drug screen was done. Based on the lack of necessary information, the request is not medically necessary.

Chiropractic/Physiotherapy three times a week for four weeks: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines - Fitness for Duty

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: The medical records provided for review do not indicate a medical necessity for Chiropractic/Physiotherapy three times a week for four weeks. The records reviewed revealed the worker has been treated with Chiropractic/Physiotherapy, however, we do not know how many visits the worker has had. The chronic pain guidelines of the MTUS recommends to allow a fading of from 3 visit a week to one visit a week for physical therapy, then to continue with home exercise therapy; while the recommendation. The Chiropractor care, discussed under manual therapy recommends the time to produce effect is 4 to 6 treatments; 1-2 visits a week for first two weeks, and to continue 1 visit a week for the next 6 weeks, with a maximum duration of 8 weeks. The requested treatment is not medically necessary.

Topical compound cream: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: The medical records provided for review do not indicate a medical necessity for topical compound cream. The MTUS regards the topical analgesics as experimental drugs recommended as an option in the treatment of neuropathic pain not responding to the first line drugs, antidepressants and anticonvulsants. Additionally, the MTUS recommends against any compound drug that contains one or more none recommended agent. The request failed to provide the name of the compound medication being requested, therefore, it is not known whether it contains a recommended agent. Therefore, this request is not medically necessary.

Interspec Interferential Unit II, Monthly supplies: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

Decision rationale: The medical records provided for review do not indicate a medical necessity for Interspec Interferential Unit II, Monthly supplies. The MTUS does not recommend Interferential Current Stimulation (ICS), because there is insufficient literature to support Interferential current stimulation for treatment of conditions like chronic pain in shoulder disorders. Therefore, this treatment is not medically necessary.

Cold Therapy Unit, Hot/Cold Pad: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 49, 203.

Decision rationale: The medical records provided for review do not indicate a medical necessity for cold therapy unit, hot/cold pad. Although the MTUS recommends at-home applications of heat or cold packs may be used before or after exercises, and are as effective as those performed by a therapist, there is no recommendation for cold therapy unit, hot/cold pad. Therefore, the requested treatment is not medically necessary.

Assay Strap: 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)

Decision rationale: The medical records provided for review do not indicate a medical necessity for Assay Strap. The Assay Strap was intended for the heat/cold pads, therefore, since the pads are not medically necessary, the assay strap is not medically necessary and appropriate.