

Case Number:	CM13-0056984		
Date Assigned:	12/30/2013	Date of Injury:	10/15/2003
Decision Date:	05/06/2015	UR Denial Date:	11/12/2013
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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: Hawaii, California, Iowa
 Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 47 year old female whose date of injury is 10/15/2003. The patient's initial diagnosis was left upper extremity complex regional pain syndrome, status post 03/16/06 left ulnar nerve transposition; 07/14/05 open left shoulder rotator cuff repair with arthroscopic distal clavicle excision and acromioplasty; and 06/09/04 left shoulder acromioplasty. The patient underwent surgery to decompress the left brachial plexus, ulnar nerve and median nerve on 04/10/13. Note dated 10/17/13 indicates that the patient complains of radiating left upper extremity pain, cold and weak arm and hypersensitivity to touch. The patient reported poor results from prior surgery performed on 04/10/13 followed by an injection on 05/02/13 that only provided temporary relief. On physical examination there is tenderness to the surgical site, spasm of the left trapezius and scapularis and increased pain with Spurling's. The treating provider has requested one pain management consultation for injection scalene muscle under UR guidance, transportation to all medical appointments, thermophore moist heating pad, and a neurology consultation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Transportation to all medical appointments between 10/17/2013 and 12/20/2013: 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) Neck and Upper Back Chapter, Office Visits, Knee Chapter (CMS 2009), Transportation to and from medical appointment.

Decision rationale: MTUS does not address transportation, so alternate guidelines were utilized. ODG states regarding transportation: "Recommended for medically-necessary transportation to appointments in the same community for patients with disabilities preventing them from self-transport. (CMS, 2009)" Medical documentation does not provide evidence that the patient has sufficient functional limitations restricting self-transportation. As such, the request for transportation to all medical appointments is not medically necessary at this time.

Neuro consultation between 10/17/2013 and 12/20/2013: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): s 165-194.

Decision rationale: The original utilization review dated 10/31/2014 had certified the request for one neurology consultation between 10/21/2014 through 12/14/2013. It is unclear if the treating physician is requesting additional neurological evaluation in addition to the original consultation visits. The treatment records provided do not substantiate the need for additional neurological visits that are in addition to what was originally approved. Therefore, the request is not medically necessary.

Thermophore moist heating pad, between 10/17/2013 and 12/20/2013: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): s 173-174. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): s 173-174. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back (Acute & Chronic), Heat/cold applications.

Decision rationale: Thermophore is a commercially available electronic heating pad with various heat settings. ACOEM and ODG comment on heat/cold packs, "Recommended." Insufficient testing exists to determine the effectiveness (if any) of heat/cold applications in treating mechanical neck disorders, though due to the relative ease and lack of adverse effects, local applications of cold packs may be applied during first few days of symptoms followed by

applications of heat packs to suit patient." There is no evidence to specifically recommend electronically controlled heating pads. The guidelines do appear to recommend short term use of heat application, but does further state that the evidence is supportive. With a date of injury of 2003, the patient is significantly past the 'acute' phase of the injury. As such, the request for one thermophore moist heating pad is not medically necessary.

1 Pain management consult for injection scalene muscle under fluoroscopic guidance between 10/17/2013 and 12/20/2013: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): s 174-17.

Decision rationale: ACOEM states, "Invasive techniques (e.g., needle acupuncture and injection procedures, such as injection of trigger points, facet joints, or corticosteroids, lidocaine, or opioids in the epidural space) have no proven benefit in treating acute neck and upper back symptoms. However, many pain physicians believe that diagnostic and/or therapeutic injections may help patients presenting in the transitional phase between acute and chronic pain." "Injection scalene muscle under US guidance" would be considered invasive as outlined above. Additionally, medical documents provided do not indicate that the patient has failed treatment of other recommended modalities leaving only invasive treatment techniques as the next step. Since the medical documents do not indicate a medical need, at this time, for scalene injection under US, the pain management consult requested is also not necessary. As such, the request for "one pain management consult for injection scalene muscle under UR guidance" is not medically necessary at this time.