

Case Number:	CM15-0008970		
Date Assigned:	01/27/2015	Date of Injury:	02/05/2010
Decision Date:	03/26/2015	UR Denial Date:	12/23/2014
Priority:	Standard	Application Received:	01/15/2015

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: California, Arizona
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 female who reported an injury on 02/05/2010. Her date of birth was not provided. On 12/31/2014, she presented for a followup evaluation regarding her work related injury. She stated that her neck pain and pain in both shoulders was relatively constant and that she had good and bad days, but the pain increased with cold weather. It was noted she had had physical therapy in the past and acupuncture and was requesting aqua therapy. The physical examination showed that she had tenderness along the cervical paraspinal muscles and pain along both shoulders, rotator cuff, and biceps tendon. There was full strength to resisted function. She was diagnosed with neck pain due to myofascial syndrome with trigger points in the right trapezius and right cervical paraspinals, referred pain in the right arm, right medial and lateral epicondylitis, bilateral shoulder impingement right greater than left, right thumb CMC joint arthritis, and ring finger PIP joint inflammation of the right hand. The treatment plan was for a cervical traction with air bladder, cervical pillow, hot and cold wrap, replacement TENS pack, Tylenol No. 3 #30, Nalfon 400 mg #60, and Protonix 20 mg #60. The rationale for treatment was not stated.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical traction with air bladder: Upheld

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

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, Collars.

Decision rationale: The Official Disability Guidelines indicate that traction is recommended for those with radicular symptoms in conjunction with a home exercise program. The documentation provided does not indicate that the injured worker has radicular symptoms or that she is performing a home exercise program. Also, it is unclear whether this is being requested as a purchase or a rental. Therefore, the request is not supported. As such, the request is not medically necessary.

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, 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 Official Disability Guidelines indicate that cervical pillows are recommended for neck support while sleeping in conjunction with daily exercise. The documentation provided does not indicate that the injured worker is performing daily exercise or that she is having neck pain while sleeping. Also, a clear rationale was not provided for the medical necessity of a cervical pillow. Therefore, the request is not supported. As such, the request is not medically necessary.

Hot and 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): 173.

Decision rationale: The California ACOEM Guidelines indicate that comfort is often the first concern that nonprescription analgesics will provide sufficient relief for most injured workers with acute and subacute symptoms. Based on the clinical documentation submitted for review, the injured worker was noted to be symptomatic regarding the cervical spine. However, there is a lack of documentation stating a clear rationale as to why the injured worker cannot use at home hot and cold therapies. A clear rationale was also not stated for the medical necessity of a hot

and cold wrap, and further clarification is needed regarding whether this is being requested as a purchase or rental. Therefore, the request is not supported. As such, the request is not medically necessary.

Replacement of TENS pad: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of TENS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 115-117.

Decision rationale: The California MTUS Guidelines indicate that, while using a TENS unit, there should be documentation of a satisfactory response and documentation regarding how often the unit was used and the duration of use. The clinical documentation submitted for review does not show how often the unit was used or the duration of use with each session. There is also a lack of evidence showing that she has had a quantitative decrease in pain or an objective improvement in function with the use of the TENS unit to support replacement pads. Also, a clear rationale was not provided for the medical necessity of replacement pads and there was no indication that the injured worker's TENS unit was not working properly. Therefore, the request is not supported. As such, the request is not medically necessary.

Tylenol no. 3 #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines On-Going Management Page(s): 78.

Decision rationale: The California MTUS Guidelines indicate that an ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should be performed during opioid therapy. The documentation provided does not show that the injured worker is having a quantitative decrease in pain or an objective improvement in function with the use of this medication to support its continuation. Also, official CURES reports or urine drug screens were not provided for review to validate her compliance. Furthermore, the frequency of the medication was not stated within the request. Therefore, the request is not supported. As such, the request is not medically necessary.

Nalfon 400mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 67-68.

Decision rationale: The California MTUS Guidelines indicate that NSAIDs are recommended for the short term symptomatic relief of low back pain. The documentation provided does not show that the injured worker is having a quantitative decrease in pain or an objective improvement in function with the use of this medication to support its continuation. Also, further clarification is needed regarding how long the injured worker has been using this medication for treatment as it is only recommended for short term therapy. Also, the frequency of the medication was not stated within the request. Therefore, the request is not supported. As such, the request is not medically necessary.

Protonix 20mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI Symptoms and Cardiovascular Risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs and GI Risks Page(s): 67-68.

Decision rationale: The California MTUS Guidelines indicate that proton pump inhibitors are recommended for the treatment of dyspepsia secondary to NSAID therapy and for those who are at high risk for gastrointestinal events due to NSAID therapy. The documentation provided does not indicate that the injured worker has dyspepsia secondary to NSAID therapy or that she is at high risk for gastrointestinal events. Therefore, the request is not supported. As such, the request is not medically necessary.