

Case Number:	CM15-0015791		
Date Assigned:	02/03/2015	Date of Injury:	12/11/2012
Decision Date:	04/07/2015	UR Denial Date:	01/21/2015
Priority:	Standard	Application Received:	01/27/2015

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: Pennsylvania, Ohio, California
 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 49 year old male, who sustained an industrial injury on December 11, 2012. The diagnoses have included history of right shoulder rotator cuff tear status post right shoulder surgery x3 with residual symptoms, mass volar aspect right forearm, and decrease in sensation nondermatomal right upper extremity. Treatment to date has included three right shoulder surgeries, carpal tunnel release in 2009, acupuncture, physical therapy, and medications. Currently, the injured worker complains of right shoulder pain, with radiation into the right deltoid, and insomnia due to pain. The Treating Physician's report dated January 5, 2015, noted the injured worker was scheduled for a right carpal tunnel release on January 23, 2015. Examination of the right shoulder was noted to show tenderness over the AC and glenohumeral joint, erythema over the right shoulder joint, and limited range of motion. Spasms were noted in the right biceps. On January 21, 2015, Utilization Review non-certified a TENS unit 30 day rental, a wrist exercise kit, standard cold therapy unit 7 day rental, Fentanyl 75 mcg #10, and Ambien 10mg #30, noting that the clinical findings did not support the medical necessity of the requested treatments. The MTUS Chronic Pain Medical Treatment Guidelines, the MTUS Post-Surgical Medical Treatment Guidelines and the Official Disability Guidelines (ODG) were cited. On January 27, 2015, the injured worker submitted an application for IMR for review of a TENS unit 30 day rental, a wrist exercise kit, standard cold therapy unit 7 day rental, Fentanyl 75 mcg #10, and Ambien 10mg #30.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS Unit, 30 day rental: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, post-operative pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 114.

Decision rationale: California Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines section on TENS, (transcutaneous electrical nerve stimulation), page 114 recommends a 30-day trial of TENS as part of an overall treatment program for multiple diagnoses including neuropathic pain. Given the neuropathic pain component of this patient's condition due to carpal tunnel syndrome, the guidelines would support this request for a 30-day TENS rental. This request is medically necessary.

Wrist Exercise Kit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Carpal Tunnel Chapter, Exercise.

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

Decision rationale: The California Medical Treatment Utilization Schedule (MTUS), 2009, Chronic Pain Medical Treatment Guidelines, section on Physical Medicine, pages 98-99 recommends individualized long-term home exercise programs. A home exercise "kit" would be indicated only if there is specific discussion of the contents of that kit and if those contents are individualized to the particular patient's goals. The records are unclear at this time in terms of the specific contents of the proposed kit. Therefore, it is not possible to apply a guideline. This request is not medically necessary.

Standard Cold Therapy Unit, 7 day rental: 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) Carpal Tunnel Syndrome Chapter, Continuous cold therapy (CCT).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 48.

Decision rationale: ACOEM Guidelines, Chapter 3, Treatment, page 48 recommends use of passive modalities such as local heat during an acute period of two weeks of treatment. Cold packs would thus be supported immediately postoperative after carpal tunnel release in this case.

However, the records and guidelines do not provide a rationale for a durable medical equipment cold therapy unit rather than cold packs. This request is not supported by the guidelines. This request is not medically necessary.

Fentayl 75mcg, #10: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioid. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Opioid.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids/Ongoing Management Page(s): 78.

Decision rationale: The California Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines section on Opioids Ongoing Management page 78 discusses the four A's of opioid management. In this case, the request for a change or increase in Fentanyl dose and continuation of fentanyl appears to be based on reports of subjective symptoms rather than based upon specific verifiable functional goals. The four A's of opioid management have not been met. This request is not medically necessary.

Ambien 10mg #30: 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) Zolpidem (ambien), Pain Chapter, Insomnia Treatment.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES, Insomnia Treatment, Ambien.

Decision rationale: This request is not discussed in the medical treatment utilization schedule. Official Disability Guidelines/Treatment in Workers Compensation/Pain discusses Ambien in the section on insomnia treatment. That guideline recommends Ambien for up to ten days. The medical records and guidelines do not provide a rationale instead for a 30-day additional trial of Ambien as proposed in this case. This request is not medically necessary.