

Case Number:	CM15-0180003		
Date Assigned:	09/21/2015	Date of Injury:	02/04/2015
Decision Date:	11/16/2015	UR Denial Date:	08/31/2015
Priority:	Standard	Application Received:	09/14/2015

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: New York

Certification(s)/Specialty: Internal 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 injured worker is a 40 year old male, who sustained an industrial injury on February 4, 2015. He reported right shoulder, right upper arm, right thumb and fingers, right wrist and hands and neck pain. The injured worker was diagnosed as having shoulder sprain and strain, severe rotator cuff tear on MRI (4-18-2015), upper arm sprain and strain, cervical spine sprain and strain with radiculopathy and disc bulges on MRI (4-18-2015), right wrist and hand sprain and strain, rule out carpal tunnel syndrome, right thumb tenosynovitis, DeQuervain's syndrome and right hand and fingers sprain and strain. Treatment to date has included diagnostic studies, medications and work restrictions. Currently, the injured worker continues to report right shoulder, right upper arm, right thumb and fingers, right wrist and hands and neck pain described as constant, severe radiating pain with weakness and associated tingling and numbness of the hands. The injured worker reported an industrial injury in 2015, resulting in the above noted pain. He was without complete resolution of the pain. Evaluation on March 20, 2015, revealed continued pain as noted. Magnetic resonance imaging (MRI) of the right shoulder, right thumb, right hand and cervical spine was recommended. The physician also recommended NCV and EMG study of his upper extremities. Evaluation on July 24, 2015, revealed continued pain as noted with unchanged subjective information. The RFA included requests for Hot/Cold Unit, Physical performance Functional Capacity Evaluation, TENS Unit and urine toxicology that were non-certified and a Physical Therapy Evaluation and treatment 3x4 (Right Shoulder) that was modified on the utilization review (UR) on August 31, 2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hot/Cold Unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Initial Care, and Forearm, Wrist, and Hand Complaints 2004, Section(s): Initial Care. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hand Chapter, Heat Therapy, Cold Therapy, Shoulder Chapters, Heat/Cold Packs.

Decision rationale: MTUS and ODG recommend at-home local applications of cold in the first few days of acute complaint of pain, followed thereafter by applications of heat or cold. Continuous low-level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. There is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful for pain reduction and return to normal function. MTUS provides no evidence recommending the routine use of high tech devices over the use of local cold or heat wraps. The request for Hot/Cold Unit is not medically necessary by guidelines.

TENS Unit: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004. Decision based on Non-MTUS Citation ODG.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: MTUS guidelines state that a TENS unit may be recommended in the treatment of chronic intractable pain conditions, if there is documentation of pain for at least three months duration, evidence that other appropriate pain modalities including medications have been tried and failed and that a one-month trial period of the TENS unit has been prescribed, as an adjunct to ongoing treatment modalities within a functional restoration program. There should be documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; rental would be preferred over purchase during this trial. A treatment plan including the specific short- and long-term goals of treatment with the TENS unit should also be submitted. Documentation provided fails to indicate ongoing specific functional restoration program in conjunction to the TENS unit trial. The request for TENS Unit is not medically necessary by MTUS.

Urine Toxicology: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation ODG-TWC Pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, differentiation: dependence & addiction. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids, Urine drug tests.

Decision rationale: MTUS recommends screening patients to differentiate between dependence and addiction to opioids. Frequency of urine drug testing should be based on documented evidence of risk stratification. Patients at "low risk" of addiction/aberrant behavior should be tested within six months of initiation of therapy and on a yearly basis thereafter. Random collection is recommended. Quantitative urine drug testing is not recommended for verifying compliance without evidence of necessity. Documentation does not show that the injured worker is being treated with Opioid analgesics or at high risk of addiction or aberrant behavior to establish the medical necessity for urine drug testing. With guidelines not being met, the request for Urine Toxicology is not medically necessary.

Physical performance Functional Capacity Evaluation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, ACOEM Guidelines page 138.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Functional restoration programs (FRPs). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Programs.

Decision rationale: Per guidelines, Functional Restorative Programs were designed to use a medically directed, interdisciplinary pain management approach geared specifically to patients with chronic disabling occupational musculoskeletal disorders. They are recommended for patients with conditions that have resulted in delayed recovery. Chart documentation indicates that the injured worker is undergoing active treatment for ongoing right shoulder, right upper arm, right thumb and fingers, right wrist and hands and neck pain. Not having reached maximum medical therapy at the time of the request under review, guidelines have not been met. The request for Physical performance Functional Capacity Evaluation is not medically necessary per guidelines.

Physical Therapy Evaluation and treatment 3x4 (Right Shoulder): Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter.

Decision rationale: MTUS states that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. As time goes, one should see an increase in the active regimen of care or

decrease in the passive regimen of care and a fading of treatment of frequency. When the treatment duration and/or number of visits exceeds the guidelines, exceptional factors should be noted. MTUS and ODG guidelines recommend 10 physical therapy visits over 8 weeks for medical management of Rotator cuff impingement syndrome and 24 visits over 14 weeks for Post-surgical treatment, for arthroscopic shoulder surgery. At the time additional outpatient physical therapy was prescribed, the injured worker had undergone an initial course of physical therapy and chiropractic care with no significant improvement in pain or function. Physician reports do not show objective findings that would support the medical necessity for additional therapy. The request for Physical Therapy Evaluation and treatment 3x4 (Right Shoulder) is not medically necessary based on lack of functional improvement and MTUS.