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| Case Number: | CM15-0184376 | | |
| Date Assigned: | 09/24/2015 | Date of Injury: | 06/16/2000 |
| Decision Date: | 11/10/2015 | UR Denial Date: | 09/03/2015 |
| Priority: | Standard | Application Received: | 09/18/2015 |

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

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 46 year old male, who sustained an industrial injury on 6-16-00. The documentation on 8-18-15 noted that the injured worker has complaints of right shoulder and right elbow. The documentation noted that abduction is again tight after 90 degrees and there is resistance and at the elbow he has 45 degrees of flexion contracture and flexions to 90 degrees. There is tenderness along the biceps is noted his rotator cuff as well as the acromioclavicular (AC) joint on the right shoulder. The injured worker has been minimizing chores around the house and lifting was no more than 10 pounds. The diagnoses have included other affections of shoulder region, not elsewhere classified; impingement syndrome of the shoulder; elbow joint inflammation and element of depression and sleep disorder due to chronic pain. Treatment to date has included percocet; oxycontin; prilosec; decompression and acromioclavicular joint resection in April 2006; labral repair as well as biceps tendon release in April 2015; biceps tenodesis on 5-29-15; injections provided in October 2014 to the biceps tendon stump given significant relief; total therapy after his last surgery of 2014 consisted of 12 therapy session and two-lead transcutaneous electrical nerve stimulation unit. Magnetic resonance imaging (MRI) of the right shoulder on 4-22-15 showed status post biceps tenodesis; while there are no gross labral tears, there is evidence of prior superior labral repair and query low-grade partial-thickness tearing along the middle fibers of the supraspinatus tendon, at and adjacent to the footprint, which may be hidden or concealed at the time of arthroscopy and no full-thickness or other significant rotator cuff tearing identified. Magnetic resonance imaging (MRI) of the right shoulder on 6-22-15 showed superior labral postoperative repair; no recurrent labral tear or

paralabral cyst identified and biceps tenodesis with anchoring to the proximal humeral shaft. Magnetic resonance imaging (MRI) of the right elbow on 6-25-15 showed moderate medial and lateral elbow degenerative arthritis with subchondral bone changes and osteophytes; small glenohumeral joint effusion and no flexor or extensor tendinopathy identified. Magnetic resonance imaging (MRI) arthrogram of the right shoulder on 7-14-15 showed modified atrophy on the surface tear of the labrum and no visualization of the biceps. Ultrasound of the shoulder in June 2015 was normal. The documentation on 8-18-15 noted that a 10 panel urine screen done last month was positive for OxyContin. The original utilization review (9-3-15) denied the request on 8-18-15 for hot and cold wrap, for right upper extremity times one; four lead transcutaneous electrical nerve stimulation unit for right upper extremity times one and conductive garment for right upper extremity times one.

IMR ISSUES, DECISIONS AND RATIONALES

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

Hot and cold wrap, for right upper extremity x1: Upheld

Claims Administrator guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic Chapter, under Cold/heat packs.

Decision rationale: Based on the 08/18/15 progress report provided by treating physician, the patient presents with pain to right shoulder and right elbow. The patient is status post right shoulder decompression in 2005, SLAP repair 04/28/14, biceps tenodesis on 05/29/14, and right elbow loose body removal in 2009. The request is for Hot and cold wrap, for right upper extremity x1. Patient's diagnosis per Request for Authorization form dated 08/18/15 includes shoulder impingement and unspecified arthropathy of upper arm. Diagnosis on 08/18/15 included elbow joint inflammation status post arthroscopy, synovectomy, capsulectomy, excision along the tip of the olecranon and fenestration with quite a bit loss of motion. Physical examination on 08/18/15 revealed tenderness along the biceps, 45 degrees of flexion contracture and flexion to 90 degrees. Treatment to date has included surgeries, injections, imaging and electrodiagnostic studies, physical therapy, TENS and medications. Patient's medications include Naproxen, Trazodone, Ultracet, Effexor, Protonix, Oxycontin and Percocet. Per 09/21/15 report, the patient is to continue working modified duty. ODG Guidelines, Low Back - Lumbar & Thoracic Chapter, under Cold/heat packs Section states: "Recommended as an option for acute pain. At-home local applications of cold packs in first few days of acute complaint; thereafter, applications of heat packs or cold packs. (Bigos, 1999) (Airaksinen, 2003) (Bleakley, 2004) (Hubbard, 2004) Continuous low-level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. (Nadler 2003) The evidence for the application of cold treatment to low-back pain is more limited than heat therapy, with only three poor quality studies located that support its use, but studies confirm that it may be a low risk low cost option. (French-Cochrane, 2006) 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. (Kinkade, 2007)" Per 08/18/15 report, treater states the patient "does not have a hot and cold wrap." Medical rationale for the request was not provided. ODG guidelines recommend the use of Hot and Cold Wrap for acute pain and short-term use. In this case, the patient is postoperative, continues with shoulder and elbow pain, and has a diagnosis of shoulder impingement and unspecified arthropathy of upper arm. However, the patient suffers from chronic pain, for which the use of Hot and Cold Wrap is not supported by guidelines. Therefore, the request IS NOT medically necessary.

Four lead TENS unit, for right upper extremity x1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

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

Decision rationale: Based on the 08/18/15 progress report provided by treating physician, the patient presents with pain to right shoulder and right elbow. The patient is status post right shoulder decompression in 2005, SLAP repair 04/28/14, biceps tenodesis on 05/29/14, and right elbow loose body removal in 2009. The request is for Four lead TENS unit, for right upper extremity x1. Patient's diagnosis per Request for Authorization form dated 08/18/15 includes shoulder impingement and unspecified arthropathy of upper arm. Diagnosis on 08/18/15 included elbow joint inflammation status post arthroscopy, synovectomy, capsulectomy, excision along the tip of the olecranon and fenestration with quite a bit loss of motion. Physical examination on 08/18/15 revealed tenderness along the biceps, 45 degrees of flexion contracture and flexion to 90 degrees. Treatment to date has included surgeries, injections, imaging and electrodiagnostic studies, physical therapy, TENS and medications. Patient's medications include Naproxen, Trazodone, Ultracet, Effexor, Protonix, Oxycontin and Percocet. Per 09/21/15 report, the patient is to continue working modified duty. MTUS, Transcutaneous electrical nerve stimulation Section, Criteria For Use of TENS, pages 114-121 states: "(1) Documentation of pain of at least three months duration. (2) There is evidence that other appropriate pain modalities have been tried (including medication) and failed. (3) A one-month trial period of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with 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. (4) Other ongoing pain treatment should also be documented during the trial period including medication usage. (5) A treatment plan including the specific short- and long-term goals of treatment with the Tens unit should be submitted. (6) A 2-lead unit is generally recommended; if a 4-lead unit is recommended, MTUS recommends TENS for neuropathic pain, CRPS, Multiple Sclerosis, Phantom pain, and spasticity pain." Per 08/18/15 report, treater states the patient "does have a two-lead TENS unit." Medical rationale for a replacement 4 lead unit has not been provided, and treater has not documented efficacy from the use of TENS. MTUS requires documentation of how often the unit was used and pain relief, prior to dispensing home units. Furthermore, the patient does not present with a diagnosis indicated for the use of TENS. MTUS recommends TENS for neuropathic pain, CRPS, Multiple Sclerosis, Phantom pain, and

spasticity pain. This patient presents with shoulder and elbow pain. This request is not in accordance with guidelines. Therefore, the request IS NOT medically necessary.

Conductive garment, for right upper extremity x1: Upheld

Claims Administrator guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004.

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

Decision rationale: Based on the 08/18/15 progress report provided by treating physician, the patient presents with pain to right shoulder and right elbow. The patient is status post right shoulder decompression in 2005, SLAP repair 04/28/14, biceps tenodesis on 05/29/14, and right elbow loose body removal in 2009. The request is for Conductive garment, for right upper extremity x1. Patient's diagnosis per Request for Authorization form dated 08/18/15 includes shoulder impingement and unspecified arthropathy of upper arm. Diagnosis on 08/18/15 included elbow joint inflammation status post arthroscopy, synovectomy, capsulectomy, excision along the tip of the olecranon and fenestration with quite a bit loss of motion. Physical examination on 08/18/15 revealed tenderness along the biceps, 45 degrees of flexion contracture and flexion to 90 degrees. Treatment to date has included surgeries, injections, imaging and electrodiagnostic studies, physical therapy, TENS and medications. Patient's medications include Naproxen, Trazodone, Ultracet, Effexor, Protonix, Oxycontin and Percocet. Per 09/21/15 report, the patient is to continue working modified duty. MTUS, Transcutaneous electrical nerve stimulation Section, TENS, pages 114-121 states: "A one-month trial period of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function. For the conditions described below". The guideline states the conditions that TENS can be used for are: Neuropathic pain, Phantom limb pain and CRPS II, Spasticity, and Multiple sclerosis (MS). It appears this is an associated request for a conductive garment to be used with TENS unit. Per 08/18/15 report, treater states the patient "does have a two-lead TENS unit." In this case, medical rationale for the request has not been provided, and treater has not documented efficacy from the use of TENS. MTUS requires documentation of how often the unit was used and pain relief, prior to dispensing home units. Furthermore, the patient does not present with a diagnosis indicated for the use of TENS. MTUS recommends TENS for neuropathic pain, CRPS, Multiple Sclerosis, Phantom pain, and spasticity pain. This patient presents with shoulder and elbow pain. This request is not in accordance with guidelines. Therefore, the request IS NOT medically necessary.