

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM14-0117188 | | |
| Date Assigned: | 08/04/2014 | Date of Injury: | 02/13/2012 |
| Decision Date: | 09/30/2014 | UR Denial Date: | 06/24/2014 |
| Priority: | Standard | Application Received: | 07/24/2014 |

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. The expert reviewer is Board Certified in Family Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 55-year-old female patient who reported an industrial injury to the shoulder and back on 2/13/2012, 2 ½ months ago, attributed to the performance of customary job tasks. The patient subsequently underwent left shoulder arthroscopic SLAP lesion debridement, chondroplasty with microfracture, humeral defect, arthroscopic subacromial decompression, and open distal claviclectomy during 2013. The patient was noted to have relief to her postoperative shoulder in PT by using the TENS unit. The patient reported decrease medications and able to move her arm better. A one-month trial was discussed. The patient reported doing better while under the care of the psychiatrist. Patient reported persistent pain to the left shoulder, left hand, and wrist. The patient was taking Percocet 10/325 mg. The objective findings on examination included left wrist with restricted range of motion and persistent tenderness over the radial wrist joint and pain with any sort of resisted rotation; Tinel's and Phalen's test were positive on the right; range of motion left shoulder decreased at 90° and forward flexion and 70° in abduction; lumbar spine demonstrated persistent tenderness. The MRI the lumbar spine documented evidence of L4-L5 mild broad central disc protrusion and L5-S1 minimal disc bulge with left lateral annular tear. The treatment plan included a 30 days home trial TENS unit directed to the shoulder and a lumbar epidural steroid injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS (transcutaneous electrical nerve stimulation) unit for a 30 day home trial: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS (transcutaneous electrical nerve stimulation), chronic pain.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 12 Low Back Complaints Page(s): 300; 203, Chronic Pain Treatment Guidelines TENS unit chronic pain Page(s): 114-117. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) forearm, wrist, hand--TENS unit; Pain chapter--TENS unit.

Decision rationale: The requesting provider did not provide subjective/objective evidence to support the medical necessity of the TENS Unit or the electronic muscle stimulator for the treatment of the postoperative right shoulder. The ACOEM Guidelines do not recommend the use of TENS Units for neck, shoulder, elbow, or wrist as there is no objective evidence available to support their use. There is no justification for the use of the 4-lead TENS unit as required by the CA MTUS. The use of the TENS unit for the treatment for the wrist/hand/forearm is not recommended by the CA MTUS or the ACOEM Guidelines. There is no objective evidence provided to support the medical necessity of the requested TENS Unit or electric muscle stimulator for the treatment of the hand/forearm for the effects of the industrial injury. The TENS unit is directed to chronic right postoperative shoulder pain issues. The patient was noted to have used a TENS unit during PT rehabilitation; however, there was no documented functional improvement with the use of the tens unit and no demonstrated reduction in the use of medications for the postoperative shoulder. There was no objective evidence to justify the continued use of the tens unit in the treatment plan for this patient. The CA MTUS and the Official Disability Guidelines only recommends the use of the TENS unit for chronic lower back pain with a demonstrated exercise program for conditioning and strengthening. The TENS Unit is recommended for only chronic intractable pain. There was no provided documentation that the patient was participating in a self-directed home exercise program. The ACOEM Guidelines revised back chapter 4/07/08 does recommend the use of the TENS Unit for the treatment of chronic lower back pain; however, it must be as an adjunct to a functional rehabilitation program and ongoing exercise program. The CA MTUS only recommend the use of the TENS unit for chronic lower back pain with a demonstrated exercise program for conditioning and strengthening. There are no recommendations for the use of the TENS Unit in the treatment of the wrist, forearm, or hand. There is no objective evidence provided by the requesting provider that the same results cannot be achieved with a home exercise program established for functional rehabilitation with strengthening and conditioning directed to the hand. There is no demonstrated medical necessity for the provision of a TENS for the rehabilitation of the shoulder for the reported chronic pain status post right shoulder arthroscopy. Given the above the request is not medically necessary.

Lumbar epidural injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300; 179-180. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Section low back chapter lumbar spine ESI.

Decision rationale: The criteria required by the CA MTUS for the provision of a lumbar ESI were not documented. The patient does meet the CA MTUS criteria for a lumbar ESI under fluoroscopic guidance. The use of lumbar spine ESIs is recommended for the treatment of acute or subacute radicular pain in order to avoid surgical intervention. The patient is not noted to have objective findings on examination consistent with a nerve impingement radiculopathy. The reported radiculopathy was not corroborated by imaging studies or Electrodiagnostic studies. There is no impending surgical intervention. The patient is being treated for chronic low back pain attributed to an annular tear and lumbar spine DDD. There is no documented rehabilitation effort. The stated diagnoses and clinical findings do not meet the criteria recommended by evidence-based guidelines for the use of a lumbar ESI by pain management. The CA MTUS requires that "Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or Electrodiagnostic testing." The ACOEM Guidelines updated Back Chapter revised 8/08/08 does not recommend the use of lumbar ESIs for chronic lower back pain. The Official Disability Guidelines recommend that ESIs are utilized only in defined radiculopathies and a maximum of two lumbar diagnostic ESIs and a limited number of therapeutic lumbar ESIs are recommended in order for the patient to take advantage of the window of relief to establish an appropriate self-directed home exercise program for conditioning and strengthening. The criteria for a second diagnostic ESI is that the claimant obtain at least 50% relief from the prior appropriately placed ESI. The therapeutic lumbar ESIs are only recommended, "If the patient obtains 50-70% pain relief for at least 6-8 weeks." Additional blocks may be required; however, the consensus recommendation is for no more than four (4) blocks per region per year. The indications for repeat blocks include "acute exacerbations of pain or new onset of symptoms." Lumbar ESIs should be performed at no more than two levels at a session. Although epidural injection of steroids may afford short-term improvement in the pain and sensory deficits in patients with radiculopathy due to herniated nucleus pulposus, this treatment, per the guidelines, seems to offer no significant long-term functional benefit, and the number of injections should be limited to two, and only as an option for short-term relief of radicular pain after failure of conservative treatment and as a means of avoiding surgery and facilitating return to activity. The patient is being treated for a subjective radiculitis with reported chronic low back without MRI or EMG/NCV evidence of a nerve impingement radiculopathy. There is no demonstrated medical necessity for a lumbar spine ESI for the reported chronic pain issues. Given the above the request is not medically necessary.