

<b>Case Number:</b>	CM14-0125256		
<b>Date Assigned:</b>	09/24/2014	<b>Date of Injury:</b>	12/22/2012
<b>Decision Date:</b>	10/24/2014	<b>UR Denial Date:</b>	07/09/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/07/2014

### 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 Preventative Medicine and is licensed to practice in Indiana. 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 employee is a 38 year old male with date of injury of 12/22/2012. A review of the medical records indicate that the patient is undergoing treatment for left shoulder pain after an industrial injury and subsequent surgery. Subjective complaints include continued 6/10 shoulder pain with and without movement. Objective findings include decreased range of motion of left shoulder; pain upon palpation of the rotator cuff area. Treatment has included Interspec interferential device, myofascial release, and hot/cold packs. The utilization review dated 7/9/2014 non-certified compounded medications (no further details), chiropractic sessions, urine analysis, MRI of left shoulder, Interspec IF, motorized cold therapy unit, and functional capacity exam.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Compound Medication ( no strength or quantity): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): page 112-113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Compound creams

**Decision rationale:** MTUS states, "There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." With no further detail on what the compound medication consists of, there is no evidence to suggest that this would be an appropriate treatment modality. Therefore, the request for a compound medication (no further details) is not medically necessary.

**Chiropractic physiotherapy 3 X 4 (12 sessions):** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): page 203. Decision based on Non-MTUS Citation Official Disability Guidelines Shoulder Chapter

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MANUAL THERAPY & MANIPULATION Page(s): 58-60. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Upper extremity-shoulder (Acute & Chronic), Chiropractic, Manipulation

**Decision rationale:** ODG recommends chiropractic treatment as an option and states the following: "Sprains and strains of shoulder and upper arm: Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home therapy 9 visits over 8 weeks" Additionally, MTUS states "Recommended as an option. Therapeutic care- Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Elective /maintenance care - Not medically necessary. Recurrences/flare-ups - Need to reevaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months." Medical documents indicate that patient has undergone approximately 24 chiropractic sessions, which would not be considered in the 'trial period' anymore. The treating provider has not demonstrated evidence of objective and measurable functional improvement during or after the trial of therapeutic care to warrant continued treatment. As such, the request for 12 sessions of chiropractic manipulation is not medically necessary.

**Urine Drug Screening:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, UA testing.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS AND SUBSTANCE ABUSE Page(s): 74-96; 108-109. Decision based on Non-MTUS Citation University of Michigan Health System Guidelines for Clinical Care: Managing Chronic Non-terminal Pain, Including Prescribing Controlled Substances (May 2009), pg 32 Established Patients Using a Controlled Substance

**Decision rationale:** MTUS states that use of urine drug screening for illegal drugs should be considered before therapeutic trial of opioids are initiated. Additionally, "Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control. Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion)." would indicate need for urine drug screening. There is insufficient documentation provided to suggest

issues of abuse, addiction, or poor pain control by the treating physician. University of Michigan Health System Guidelines for Clinical Care: Managing Chronic Non-terminal Pain, Including Prescribing Controlled Substances (May 2009 recommends for stable patients without red flags" Twice yearly urine drug screening for all chronic non-malignant pain patients receiving opioids - once during January-June and another July-December". There is no medical documentation that the patient has been on chronic opioid therapy. As such, the request for urine drug screen is not medically necessary.

### **Functional Capacity Exam: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, FCE

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation Page(s): 21-42. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness for Duty, Functional capacity evaluation (FCE)

**Decision rationale:** ACOEM guidelines state "Consider using a functional capacity evaluation when necessary to translate medical impairment into functional limitations and determine work capability". Additionally, "It may be necessary to obtain a more precise delineation of patient capabilities than is available from routine physical examination. Under some circumstances, this can best be done by ordering a functional capacity evaluation of the patient." Progress notes by the treating physician state clearly outline what the patient's limitations are and make no indication that additional delineation of the patient's capabilities are necessary to determine return to work. ODG further specifies guidelines for functional capacity evaluations "Recommended prior to admission to a Work Hardening (WH) Program.", "An FCE is time-consuming and cannot be recommended as a routine evaluation.", "Consider an FCE if 1. Case management is hampered by complex issues such as: - Prior unsuccessful RTW attempts. - Conflicting medical reporting on precautions and/or fitness for modified job. - Injuries that require detailed exploration of a worker's abilities. 2. Timing is appropriate: - Close or at MMI/all key medical reports secured. - Additional/secondary conditions clarified." The medical documents provided do not indicate that any of the above criteria were met. As such, the request for baseline functional capacity evaluation is not medically indicated.

### **MRI Left Shoulder: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Shoulder Chapter, Imaging

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209, 213. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Magnetic resonance imaging (MRI)

**Decision rationale:** ACOEM states 'Primary criteria for ordering imaging studies are:- Emergence of a red flag (e.g., indications of intra-abdominal or cardiac problems presenting as

shoulder problems)- Physiologic evidence of tissue insult or neurovascular dysfunction (e.g., cervical root problems presenting as shoulder pain, weakness from a massive rotator cuff tear, or the presence of edema, cyanosis or Raynaud's phenomenon)- Failure to progress in a strengthening program intended to avoid surgery.- Clarification of the anatomy prior to an invasive procedure (e.g., a full thickness rotator cuff tear not responding to conservative treatment)" ODG states "Indications for imaging Magnetic resonance imaging (MRI):- Acute shoulder trauma, suspect rotator cuff tear/impingement; over age 40; normal plain radiographs- Subacute shoulder pain, suspect instability/labral tear- Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. (Mays, 2008)". The employee does not meet any of the above criteria, and so the request for an MRI of the left shoulder is not medically necessary.

**Motorized cold therapy unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): page 203. Decision based on Non-MTUS Citation Official Disability Guidelines Shoulder Chapter , Continuous flow Cryotherapy

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute & Chronic), Heat/cold applications

**Decision rationale:** Thermophore is a commercially available electronic heating pad with various heat settings. ACOEM and ODG comment on heat/cold packs, "Recommended. Insufficient testing exists to determine the effectiveness (if any) of heat/cold applications in treating mechanical neck disorders, though due to the relative ease and lack of adverse affects, local applications of cold packs may be applied during first few days of symptoms followed by applications of heat packs to suit patient". There is no evidence to specifically recommend electronically controlled cooling pads. The guidelines to appear to recommend short term use of cold application, but does further state that the evidence is supportive. With a date of injury of 2012, the patient is significantly past the 'acute' phase of the injury. As such, the request for one motorized cold therapy unit is not medically necessary.

**Purchase Interspec IF II unit with monthly supplies:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential current. Decision based on Non-MTUS Citation Official Disability Guidelines Interferential current

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315, Chronic Pain Treatment Guidelines Interferential Current Stimulation, Transcutaneous electrotherapy Page(s): 54, 114-116, 118-120.

**Decision rationale:** ACOEM guidelines state "Insufficient evidence exists to determine the effectiveness of sympathetic therapy, a noninvasive treatment involving electrical stimulation, also known as interferential therapy. At-home local applications of heat or cold are as effective

as those performed by therapists." MTUS further states regarding inferential units, "Not recommended as an isolated intervention" and details the criteria for selection:- Pain is ineffectively controlled due to diminished effectiveness of medications; or - Pain is ineffectively controlled with medications due to side effects; or - History of substance abuse; or - Significant pain from postoperative conditions limits the ability to perform exercise programs/ physical therapy treatment; or- Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). "If those criteria are met, then a one-month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits."While the medical documents do indicate that the pain is ineffectively controlled, the treating physician does not specifically attribute the uncontrolled pain due to "diminished effectiveness of medications" or poor control of pain with medications "due to side effects". In fact, the medical documentation does not even list the current medication the employee is taking for pain control. Additionally, the medical documentation does not detail any concerns for substance abuse or pain from postoperative conditions that limit ability to participate in exercise programs/treatments. The medical documents do indicate ongoing physical therapy and/or chiropractic treatment (unknown number of sessions); however, progress notes do not detail unresponsiveness to other conservative measures such as repositioning, heat/ice, etc. As such, the request for Purchase Interspec IF II unit is not medically necessary.