

Case Number:	CM14-0147159		
Date Assigned:	10/17/2014	Date of Injury:	06/27/2011
Decision Date:	11/24/2014	UR Denial Date:	08/12/2014
Priority:	Standard	Application Received:	09/10/2014

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 Occupational 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:

The applicant is a represented [REDACTED] employee who has filed a claim for chronic neck pain, low back pain, and bilateral shoulder pain reportedly associated with an industrial injury of June 27, 2011. Thus far, the applicant has been treated with the following: analgesic medications; psychotropic medications; unspecified amounts of physical therapy; and unspecified amounts of manipulative therapy. In a Utilization Review Report dated August 12, 2014, the claims administrator denied a TENS unit, denied an associated conductive garment, denied a cervical traction device, denied a lumbar orthotic, denied lumbar MRI imaging, denied cervical MRI imaging, approved Remeron, denied Lidoderm patches, approved tramadol, approved a psychiatry referral, approved a physiatry referral, denied 12 sessions of manipulative therapy, denied shoulder corticosteroid injections, and denied a cold compression garment. The applicant's attorney subsequently appealed. In a July 30, 2014 progress note, the applicant reported ongoing complaints of neck, shoulder, low back, and wrist pain. The applicant denied any paresthesias. The applicant denied any radiating neck pain. The applicant stated that she never had any epidural injections. The applicant's blood pressure was elevated at 176/95. The applicant had positive impingement signs about the bilateral shoulders. The applicant was given diagnosis of axial neck pain, shoulder impingement syndrome, low back pain, coccydynia, and wrist pain. It was stated that the applicant was reportedly working as a cook. The applicant was having issues with psychological stress and depression. The attending provider then stated that the applicant had "no income or car" while incongruously stating that the applicant was working. A TENS unit, associated conductive garment, cervical traction device, lumbar support, hot and cold compressive garment, 12 sessions of manipulative therapy, shoulder corticosteroid injection therapy, physiatry referral, MRI imaging of the cervical and lumbar spines, Lidoderm, Naproxen, Tramadol, Protonix, and Remeron were all sought while the applicant was apparently returned to

work. The remainder of the file was surveyed. There was no explicit statement from either the attending provider or the claims administrator to the effect that the applicant had had prior shoulder corticosteroid injection therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS unit (home): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 298-301.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of TENS Page(s): 116.

Decision rationale: As noted on page 116 of the MTUS Chronic Pain Medical Treatment Guidelines, provision with a TENS unit and/or provision of associated supplies beyond an initial one-month trial should be predicated on evidence of favorable outcome in terms of both pain relief and function during said one-month trial of the TENS unit. In this case, however, the attending provider seemingly sought authorization for the TENS unit without conducting a one-month trial of the same. Therefore, the request is not medically necessary.

Conductive garment: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Cervical traction with an air bladder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 173.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181 and 174.

Decision rationale: As noted in the MTUS-adopted ACOEM Guidelines in Chapter 8, Table 8-8, page 181, traction, the modality at issue is deemed "not recommended." In this case, the attending provider did not furnish any compelling applicant-specific rationale or medical evidence which would offset the unfavorable ACOEM position on the article at issue. It is further noted that, as with the request for the TENS unit, the attending provider seemingly sought authorization to purchase the device without evidence of a previous trial of the same. While ACOEM Chapter 8, page 174 does suggest that palliative tools such as traction can be employed on a trial basis, in this case, however, the attending provider seemingly sought authorization to

purchase the traction device without evidence of a previously successful trial of the same. The request, thus, as written, runs counter to ACOEM principles and parameters. Therefore, the request is not medically necessary.

Lumbar orthosis, bolster pad: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

Decision rationale: As noted in the MTUS-adopted ACOEM Guidelines in Chapter 12, page 301, lumbar supports are not recommended outside of the acute phase of symptom relief. In this case, the applicant was, quite clearly, well outside of the acute phase of symptom relief following an industrial injury of June 27, 2011 as of the date of the Utilization Review Report, August 12, 2014. Introduction and/or ongoing usage of a lumbar orthosis or lumbar support are not indicated at this late stage in the life of the claim. Therefore, the request is not medically necessary.

MRI study-lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303 and 304.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304.

Decision rationale: As noted in the MTUS-adopted ACOEM Guidelines in Chapter 12, page 304, imaging studies should be reserved for cases in which surgery is being considered or red-flag diagnoses are being evaluated. In this case, there is no evidence that the applicant is actively considering or contemplating any kind of surgical intervention involving the lumbar spine on or around the date of the request. Therefore, the request is not medically necessary.

MRI study-cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): Table 8-8, 182.

Decision rationale: While the MTUS Guideline in ACOEM Chapter 8, Table 8-8, page 182 does recommend MRI or CT imaging of the cervical spine to help validate a diagnosis of nerve root compromise, based on clear history and physical exam findings, in preparation for an invasive procedure, in this case, however, the multifocal nature of the applicant's complaints

and/or ancillary complaints of psychological stress seemingly call into question the presence of any focal neurologic compromise involving the cervical spine. There was, furthermore, no explicit statement (or implicit expectation) on the part of the attending provider that the applicant would act on the results of the proposed cervical MRI and/or consider surgical intervention involving the same. Therefore, the request is not medically necessary.

Lidoderm patches 5% #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Lidocaine Page(s): 112.

Decision rationale: While page 112 of the MTUS Chronic Pain Medical Treatment Guidelines does acknowledge that topical Lidocaine can be employed in the treatment of localized peripheral pain/neuropathic pain in applicants in whom there has been a trial of first-line therapy with antidepressants and/or anticonvulsants, in this case, however, there was no evidence that antidepressant adjuvant medications and/or anticonvulsant adjuvant medications were trialed and/or failed before the Lidoderm patches at issue were introduced. Therefore, the request is not medically necessary.

12 visits chiropractic therapy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-301. Decision based on Non-MTUS Citation Official Disability Guidelines, Online treatment Guidelines, (http://www.odg-twc.com/odgtwc/low_back.htm), Low back manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58.

Decision rationale: As noted on page 58 of the MTUS Chronic Pain Medical Treatment Guidelines, the time deemed necessary to produce effect following introduction of manipulative therapy is "four to six treatments." The request, thus, as written, represents initiation of treatment at a rate two to three times MTUS parameters. Therefore, the request is not medically necessary.

Cortisone injection- subacromial space of the right shoulder: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): Table 9-3, 204.

Decision rationale: As noted in the MTUS-adopted ACOEM Guidelines in Chapter 9, Table 9-3, page 204, corticosteroid injection therapy into the subacromial bursa is "recommended" as an option in the treatment of impingement syndrome, the diagnosis reportedly present here. The attending provider posited that the applicant has ongoing complaints of shoulder pain, difficulty with overhead reaching, and positive signs of internal impingement appreciated on exam. There is no evidence on file to the effect that the applicant had had prior corticosteroid injection therapy involving the right shoulder. Therefore, the request is medically necessary.

Cortisone injection- subacromial space of the left shoulder: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): Table 9-3, 204.

Decision rationale: As noted in the MTUS-adopted ACOEM Guidelines in Chapter 9, Table 9-3, page 204, corticosteroid injection therapy into the subacromial bursa is "recommended" as an option in the treatment of impingement syndrome, the diagnosis reportedly present here. The attending provider posited that the applicant has ongoing complaints of shoulder pain, difficulty with overhead reaching, and positive signs of internal impingement appreciated on exam. There is no evidence on file to the effect that the applicant had had prior corticosteroid injection therapy involving the right shoulder. Therefore, the request is medically necessary.

Cold compression garment: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): Table 12-5.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 174, 204 and 299.

Decision rationale: The primary pain generators here are the neck, low back, and shoulders. While the MTUS Guideline in ACOEM Chapter 9, Table 9-3, the MTUS Guideline in ACOEM Chapter 8, Table 8-5, page 174, and the MTUS Guideline in ACOEM Chapter 12, Table 12-5, page 299, all recommend at-home local applications of heat and cold as methods of symptom control for shoulder, neck, and low back pain complaints, as are present here, by implication, thus, ACOEM does not support more elaborate devices such as the cold compression garment at issue to deliver cryotherapy. Therefore, the request is not medically necessary.