

Case Number:	CM14-0170305		
Date Assigned:	10/20/2014	Date of Injury:	05/10/2010
Decision Date:	11/20/2014	UR Denial Date:	09/10/2014
Priority:	Standard	Application Received:	10/15/2014

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:

This case is a 52 years old female with a date of injury on 5/10/2010. A review of the medical records indicate that the patient has been undergoing treatment for bilateral shoulder internal derangement, cervical spine myoligamentous injury, left meniscal tear, and anxiety/depression. Subjective complaints (9/18/2014) include constant neck pain with numbness, bilateral shoulder pain, right arm/hand/wrist pain with numbness and weakness, lumbar spine pain with radiation to bilateral extremities, left knee pain, and anxiety/depression related to pain. Objective findings include (9/18/2014) include muscle spasms to upper back, decreased sensation to right hand (remaining normal), and decreased right shoulder range of motion. MRI of right wrist (8/23/2014) revealing bone cysts in the lunat and capitate, tear of the triangular fibrocartilage complex, tenosynovitis. MRI left and right shoulders (8/23/2014) reveal osteoarthritis, tendinosis of supraspinatus/infraspinatus and subacromial bursitis. Treatment has included carpal tunnel release (date not specified) norco, tramadol, and home therapy. A utilization review dated 9/10/2014 non-certified the following:- One prescription for Cyclobenzaprine 2%, Flurbiprofen 25% 180 gm cream- Right wrist Pro wrist brace purchase- Optimum shoulder kit purchase- X-Force stimulator purchase with supplies x 3 and a garment x 2 A utilization review dated 9/10/2014 non-certified the following:-One prescription for Cyclobenzaprine 2%, Flurbiprofen 25% 180 gm cream-Right wrist Pro wrist brace purchase-Optimum shoulder kit purchase-X-Force stimulator purchase with supplies x 3 and a garment x 2.

IMR ISSUES, DECISIONS AND RATIONALES

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

Solarcare infrared heating pad purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173-174. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic), Pain, Heat/cold applications

Decision rationale: The request is an 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 infrared heating pad. The guidelines appear to recommend short-term use of heat application within the first few days of injury. With a date of injury of 2010, the patient is significantly past the 'acute' phase of the injury. Medical documents do not substantiate the necessity of the product now. As such, the request for Solarcare infrared heating pad purchase is not medically necessary.

Right wrist Pro wrist brace purchase: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 262-264,268-269.

Decision rationale: MTUS is silent with regards to wrist brace. ACOEM states regarding wrist immobilization, "Splinting of wrist in neutral position at night & day" may be indicated for carpal tunnel syndrome and "Limit motion of inflamed structures with wrist and thumb splint". ACOEM further states "Limit motion of inflamed structures" for tendinitis and tenosynovitis, but does not specify with splinting. ODG (capal tunnel) refers to splinting section for braces, "splinting the wrist beyond 48 hours following CTS release may be largely detrimental, especially compared to a home physical therapy program." Medical records do indicate carpal tunnel syndrome with release greater than 48 hour ago. The treating physicia does not detail any extenuating circumstances that warrant exception to the guidelines outlined above. As such, the request for Right wrist Pro wrist brace purchase is not medically necessary at this time.

Optimum shoulder kit purchase: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Home Exercise Kit

Decision rationale: MTUS does not specifically refer to home exercise kits, but does state "Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices." ODG states regarding Home Exercise Kits, "Recommended. See Exercises, where home exercise programs are recommended; & Physical therapy, where active self-directed home physical therapy is recommended." The request for authorization for the shoulder kit lists the contents as "dual texture swiss ball with strengthening bands, yoga mat, stretch pole, overhead range of motion/strengthening bands, tone-8 strengthening bands (pair), massage roller, air pump, activity guide" The treating physician does not shoulder deficits, but does not specify the medical necessity of the components within the exercise kits. There is no clear and specific medical indication for the 'kit' as it is written. As such, the request for Optimum shoulder kit purchase is not medically necessary.

X-Force stimulator purchase with supplies times 3 and a garment times 2: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-116.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation, Transcutaneous electrotherapy Page(s): 54, 114-116, 118-120. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, TENS chronic pain (transcutaneous electrical nerve stimulation) Other Medical Treatment Guideline or Medical Evidence: www.sevensenseadm.com/force-stimulator

Decision rationale: According to the manufacturer's website, "The X-Force Stimulator is a proprietary device that utilizes a unique electrical signal to deliver monophasic, peaked impulses directly to the joint. The device is a dual modality unit, offering TEJS and TENS functions that both use electrical stimulation to combat pain found in the joint capsule." MTUS states regarding TENS unit, "Not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration, for the conditions described below." For pain, MTUS and ODG recommend TENS (with caveats) for neuropathic pain, phantom limb pain and CRPSII, spasticity, and multiple sclerosis. ODG further outlines recommendations for specific body parts: Low back: Not recommended as an isolated intervention Knee: Recommended as an option for osteoarthritis as adjunct treatment to a therapeutic exercise program Neck: Not recommended as a primary treatment modality for use in whiplash-associated disorders, acute mechanical neck disease or chronic neck disorders with radicular findings Ankle and foot: Not recommended Elbow: Not recommended Forearm, Wrist and Hand: Not recommended Shoulder: Recommended for post-stroke rehabilitation Medical records do not indicate conditions of the low back, knee, neck, ankle, elbow, or shoulders that meet guidelines. Of note, medical records do not indicate knee osteoarthritis. ODG further details criteria for the use of TENS for Chronic intractable pain (for the conditions noted above): (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) After a successful 1-month trial, continued TENS treatment may be recommended if the physician documents that the patient is likely to derive significant therapeutic benefit from continuous use of the unit over a long period of time. At this point purchase would be preferred over rental.(7) Use for acute pain (less than three months duration) other than post-operative pain is not recommended.(8) A 2-lead unit is generally recommended; if a 4-lead unit is recommended, there must be documentation of why this is necessaryThe medical records do not satisfy the several criteria for selection specifically, lack of documented 1-month trial, lack of documented short-long term treatment goals with TENS unit, and unit use for acute (less than three months) pain. As such, the request for X-Force stimulator purchase with supplies times 3 and a garment times 2 is not medically necessary.