

Case Number:	CM14-0178952		
Date Assigned:	11/03/2014	Date of Injury:	02/23/1999
Decision Date:	12/16/2014	UR Denial Date:	10/08/2014
Priority:	Standard	Application Received:	10/29/2014

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:

Patient is a 63-year-old male who has submitted a claim for rotator cuff sprain, bilateral first carpometacarpal joint osteoarthritis, and status post right shoulder arthroscopy associated with an industrial injury date 2/23/1999. Medical records from the 2013 to 2014 were reviewed. Patient complained of bilateral shoulder pain, wrist, and thumb rated 7 to 8/10 in severity. Patient was unable to proceed with left shoulder surgery because of pending home care services as he had difficulty performing activities of daily living. Patient was motorized wheelchair bound and he was receiving home care services for 4 hours per day. Physical examination of the left shoulder showed tenderness, positive impingement test, a positive cross arm test, and decreased range of motion. Treatment to date has included right shoulder arthroscopy in 1990, use of a wrist splint and medications such as Celebrex and Voltaren gel since August 2014. Utilization review from 10/9/2014 modified the request for Celebrex into Celebrex 200mg, #30 because it was prescribed for shoulder arthritis which is guideline recommended; denied one prescription for Voltaren gel #4 tubes because there was no evidence that patient had failed oral medications; denied one nurse case manager to perform home health assistance, 24 hours per day 7 days per week because of no indication as to what services for assistance should be provided to the patient; and denied wrist/thumb splints, bilateral replacement reimbursement because of no evidence of functional improvement from its use.

IMR ISSUES, DECISIONS AND RATIONALES

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

Unknown Prescription of Celebrex 200: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAID's (non-steroidal anti-inflammatory).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 46.

Decision rationale: As stated on page 46 of the California MTUS Chronic Pain Medical Treatment guidelines, NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain and that there is no evidence of long-term effectiveness for pain or function. In this case, patient has been on Celebrex since August 2014. However, there is no documentation concerning pain relief and functional improvement derived from its use. Long-term use is likewise not recommended. The request also failed to specify quantity to be dispensed. Therefore, the request for Unknown Prescription of Celebrex 200 is not medically necessary.

Voltaren Gel #4 tubes: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: As stated on pages 111-112 of California MTUS Chronic Pain Medical Treatment Guidelines, topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis. Topical diclofenac is particularly indicated for osteoarthritis and tendinitis of the knee, elbow or other joints for short-term use (4-12 weeks). In this case, patient has been using Voltaren gel since August 2014 for carpometacarpal joint osteoarthritis. However, there is no documentation concerning pain relief and functional improvement derived from its use. The medical necessity cannot be established due to insufficient information. Therefore, the request for Voltaren Gel #4 tubes is not medically necessary.

1 Nurse Manager (or similar) to perform Home Health assistance needs, 24 hours per day, 7 days a week: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Colorado Division of Worker's Compensation, rev. 12/27/2011, page 89

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Home Health Services Page(s): 51.

Decision rationale: As stated on page 51 of California MTUS Chronic Pain Medical Treatment Guidelines, home health services are only recommended for otherwise recommended medical

treatment for patients who are homebound, generally up to no more than 35 hours per week. Medical treatment does not include homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom when this is the only care needed. In this case, patient is currently receiving home care services for 4 hours per day. He is motorized wheelchair bound. Patient complains of bilateral shoulder pain, wrist, and thumb rated 7 to 8/10 in severity. Patient is unable to proceed with left shoulder surgery because of pending home care services as he has difficulty performing activities of daily living. Physical examination of the left shoulder showed tenderness, positive impingement test, positive cross arm test, and decreased range of motion. However, there is no clear indication in the medical records provided that the patient has a need of professional nursing services for the purposes of home health. Furthermore, the present request of duration of treatment period exceeded guideline recommendation of no more than 35 hours per week. There is no discussion concerning need for variance from the guidelines. Therefore, the request for 1 Nurse Manager (or similar) to perform Home Health assistance needs, 24 hours per day, 7 days a week is not medically necessary.

1 - 6 inch wrist/thumb splints, bilateral replacement reimbursement: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines): Forearm, Wrist, & hand (Acute & Chronic)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 156.

Decision rationale: According to pages 156 of the ACOEM Practice Guidelines referenced by California MTUS, splints encourage lack of mobility which likely impairs or delays recovery with potentially increasing risk of complex regional pain syndrome, debility and delayed recovery. There are limited indications for splints in patients with select diagnoses generally involving more extensive surgical procedures or other needs to utilize splints for protective purposes. In this case, patient complains of bilateral wrist and thumb pain rated 7 to 8/10 in severity. Patient has been using his splint without reported symptom relief or functional improvement from its use. There is likewise no objective finding of deficits pertaining to the wrist / hand that may necessitate its use. The medical necessity cannot be established due to insufficient information. Therefore, the request for one -six inch wrist/thumb splints, bilateral replacement reimbursement is not medically necessary.