Case Number:	CM15-0140798		
Date Assigned:	08/13/2015	Date of Injury:	08/20/2013
Decision Date:	10/09/2015	UR Denial Date:	06/16/2015
Priority:	Standard	Application Received:	07/21/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: California
Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 injured worker is a 45 year old female, who sustained an industrial injury on 8-20-13. She reported pain in her left shoulder and elbow related to repetitive lifting of a heavy object. The injured worker was diagnosed as having left shoulder impingement syndrome and left lateral elbow epicondylitis. Treatment to date has included a left shoulder x-ray, physical therapy, a home exercise program, a functional capacity evaluation on 11-17-14 and topical pain medications. On 3-24-15 the injured worker reported left elbow pain is improving with physical therapy, but left shoulder pain is not. The treating physician administered a left shoulder subacromial bursa injection at the visit. On 4-21-15 the injured worker indicated some pain relief from the injection, but still noted residual left shoulder pain. As of the PR2 dated 6-2-15, the injured worker reports persistent left shoulder pain that is aggravated by lifting, reaching and pushing activities. She indicated the pain in the left elbow is improving. Objective findings include decreased left shoulder range of motion and a positive Hawkins and Neer test. The treating physician requested a home IF unit with batteries, delivery and set-up charges, a hot and cold pack-wrap and Pantoprazole DR 20mg #30.

IMR ISSUES, DECISIONS AND RATIONALES

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

Durable medical equipment (DME) home IF (interferential) unit with batteries: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: The patient presents with left arm, left shoulder, and right wrist pain rated 4/10. The request is for durable medical equipment (DME) home if (interferential) unit with batteries. The request for authorization is dated 06/09/15. Physical examination of the shoulder reveals tenderness to palpation of the AC joint. Impingement sign is positive. Decreased ROM. Decreased strength. Patient's medications include Naproxen, Pantoprazole, and Compounded Cream. Per progress report dated 06/04/15, the patient to remain off-work. MTUS, Interferential Current Stimulation (ICS) Section, pages 118-120 states, "While not recommended as an isolated intervention, Patient selection criteria if Interferential stimulation is to be used anyway: Possibly appropriate for the following conditions if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine: 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. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction." Per progress report dated 07/02/15, treater's reason for the request is "Restrict Motion / Neutral Position, Pain / Mobilization and Sprain / Strain." Treater does not mention whether the request is for a rental or purchase. In this case, MTUS supports a 30-day trial before an IF unit is recommended. A successful trial with pain reduction and functional improvement is required, if indicated. Review of provided medical records show no discussion or documentation by treater if the patient has trialed an IFC Unit. Therefore, given the lack of documentation regarding a 30-day use of the IFC unit, the request IS NOT medically necessary.

Delivery and set-up charges: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: The patient presents with left arm, left shoulder, and right wrist pain rated 4/10. The request is for delivery and set-up charges. The request for authorization is dated 06/09/15. Physical examination of the shoulder reveals tenderness to palpation of the AC joint. Impingement sign is positive. Decreased ROM. Decreased strength. Patient's medications include Naproxen, Pantoprazole, and Compounded Cream. Per progress report dated 06/04/15, the patient to remain off-work. MTUS, Interferential Current Stimulation (ICS) Section, pages 118-120 states, "While not recommended as an isolated intervention, Patient selection criteria if Interferential stimulation is to be used anyway: Possibly appropriate for the following conditions if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine: 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. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction." Treater does not discuss the request. It appears this request for Delivery and Set-up Charges are associated with the request for an IF unit. However, the request for an IF unit has not been authorized. Therefore, the request IS NOT medically necessary.

Durable medical equipment (DME) hot and cold pack/wrap: Upheld

Claims Administrator guideline: Decision based on MTUS General Approaches 2004, Section(s): Initial Approaches to Treatment, and Neck and Upper Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Low Back - Lumbar & Thoracic (Acute & Chronic Chapter - Cold/Heat packs.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic Chapter, under Cold/heat packs.

Decision rationale: The patient presents with left arm, left shoulder, and right wrist pain rated 4/10. The request is for durable medical equipment (DME) hot and cold pack/wrap. The request for authorization is dated 06/09/15. Physical examination of the shoulder reveals tenderness to palpation of the AC joint. Impingement sign is positive. Decreased ROM. Decreased strength. Patient's medications include Naproxen, Pantoprazole, and Compounded Cream. Per progress report dated 06/04/15, the patient to remain off- work.ODG Guidelines, Low Back - Lumbar & Thoracic Chapter, under Cold/heat packs Section states: "Recommended as an option for acute pain. At-home local applications of cold packs in first few days of acute complaint; thereafter, applications of heat packs or cold packs. (Bigos, 1999) (Airaksinen, 2003) (Bleakley, 2004) (Hubbard, 2004) Continuous low-level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. (Nadler 2003) The evidence for the application of cold treatment to low-back pain is more limited than heat therapy, with only three poor quality studies located that support its use, but studies confirm that it may be a low risk low cost option. (French-Cochrane, 2006) There is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful for pain reduction and return to normal function. (Kinkade, 2007)." Per progress report dated 07/02/15, treater's reason for the request is "Restrict Motion / Neutral Position, Pain / Mobilization and Sprain / Strain." The patient continues with left arm, left shoulder, and right wrist pain. ODG guidelines recommend the use of Hot and Cold Pack/Wrap for acute pain. However, the patient is diagnosed with persistent symptomatic left shoulder impingement syndrome and left elbow lateral epicondylitis. Given the patient suffers from chronic pain, there is no guideline support for Hot and Cold Pack/Wrap. Therefore, the request IS NOT medically necessary.

Pantoprazole DR (delayed release) 20mg, 1 tablet orally every day 30 minutes before meal, #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter - Proton pump inhibitors (PPIs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: The patient presents with left arm, left shoulder, and right wrist pain rated 4/10. The request is for Pantoprazole DR (delayed release) 20mg, 1 tablet orally every day 30 minutes before meal, #30. The request for authorization is dated 06/09/15. Physical examination of the shoulder reveals tenderness to palpation of the AC joint. Impingement sign is positive. Decreased ROM. Decreased strength. Patient's medications include Naproxen, Pantoprazole, and Compounded Cream. Per progress report dated 06/04/15, the patient to remain off-work. MTUS pg 69 states "NSAIDs, GI symptoms and cardiovascular risk,: Treatment of dyspepsia secondary to NSAID therapy: Stop the NSAID, switch to a different NSAID, or consider H2-receptor antagonists or a PPI." Regarding Protonix, or a proton pump inhibitor, MTUS allows it for prophylactic use along with oral NSAIDs when appropriate GI risk is present such as age greater 65; concurrent use of anticoagulants, ASA or high dose of NSAIDs; history of PUD, gastritis, etc. This medication also can be used for GI issues such as GERD, PUD or gastritis. Treater does not specifically discuss this medication. This appears to be the initial trial prescription for Pantoprazole. The patient is taking Naproxen, an NSAID. However, treater does not provide GI risk assessment for prophylactic use of PPI, as required by MTUS. And provided progress reports do not discuss or document what specific GI symptoms the patient has. Therefore, given the lack of documentation, the request IS NOT medically necessary.