

Case Number:	CM15-0177742		
Date Assigned:	09/18/2015	Date of Injury:	06/05/2014
Decision Date:	10/28/2015	UR Denial Date:	09/03/2015
Priority:	Standard	Application Received:	09/09/2015

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, District of Columbia, Maryland
 Certification(s)/Specialty: Anesthesiology, Pain Management

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 66 year old male, who sustained an industrial injury on 6-5-2014. The injured worker was diagnosed status post right shoulder surgery, right shoulder impingement syndrome with labral tear, acromioclavicular joint arthropathy and rotator cuff tear. Per AME reported dated 2-19-2015, he is being treated for pain to the neck, shoulder, upper extremities, elbows, arms, wrists, hands, mid and lower back. The request for authorization is for: work conditioning, eight (8) visits; and heating pad. The UR dated 9-3-2015: non-certified work conditioning, eight (8) visits; and heating pad. Several pages of the medical records have handwritten information which is difficult to decipher. On 5-8-2015, he reported right shoulder pain. Physical examination revealed tenderness, pain and decreased right shoulder range of motion, and positive Neer's sign and Hawkins sign on the right. On 6-29-2015, he is off work. He reported right shoulder pain. A decreased range of motion is noted. The records are unclear regarding completed sessions of post-operative physical therapy for the shoulder. There is no indication of physical therapy prior to the right shoulder surgery. The treatment and diagnostic testing to date has included: right shoulder surgery (7-7-2015), medications, magnetic resonance imaging of the cervical spine (2-6-2015), magnetic resonance imaging of the lumbar spine (2-6-2015), ultrasound bilateral shoulders (2-19-2015), ultrasound bilateral wrists (1-29-2015).

IMR ISSUES, DECISIONS AND RATIONALES

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

Work conditioning 8 visits: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder chapter. Official Disability Guidelines (ODG), Physical Medicine Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Work conditioning, work hardening.

Decision rationale: Per MTUS CPMTG with regard to work conditioning: "Recommended as an option, depending on the availability of quality programs. Criteria for admission to a Work Hardening Program: (1) Work related musculoskeletal condition with functional limitations precluding ability to safely achieve current job demands, which are in the medium or higher demand level (i.e., not clerical/sedentary work). An FCE may be required showing consistent results with maximal effort, demonstrating capacities below an employer verified physical demands analysis (PDA). (2) After treatment with an adequate trial of physical or occupational therapy with improvement followed by plateau, but not likely to benefit from continued physical or occupational therapy, or general conditioning. (3) Not a candidate where surgery or other treatments would clearly be warranted to improve function. (4) Physical and medical recovery sufficient to allow for progressive reactivation and participation for a minimum of 4 hours a day for three to five days a week. (5) A defined return to work goal agreed to by the employer & employee: (a) A documented specific job to return to with job demands that exceed abilities, OR (b) Documented on-the-job training. (6) The worker must be able to benefit from the program (functional and psychological limitations that are likely to improve with the program). Approval of these programs should require a screening process that includes file review, interview and testing to determine likelihood of success in the program. (7) The worker must be no more than 2 years past date of injury. Workers that have not returned to work by two years post injury may not benefit. (8) Program timelines: Work Hardening Programs should be completed in 4 weeks consecutively or less. (9) Treatment is not supported for longer than 1-2 weeks without evidence of patient compliance and demonstrated significant gains as documented by subjective and objective gains and measurable improvement in functional abilities. (10) Upon completion of a rehabilitation program (e.g. work hardening, work conditioning, outpatient medical rehabilitation) neither re-enrollment in nor repetition of the same or similar rehabilitation program is medically warranted for the same condition or injury. Per the documentation submitted for review, it was noted that the injured worker was status post right shoulder surgery and was to be treated with post-operative physical therapy. However, the medical records did not contain any information regarding the response to physical therapy or whether it was completed. As the (2) criteria above is not met, medical necessity cannot be affirmed.

Heating pad: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder chapter.

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, Heat Therapy.

Decision rationale: Per the ODG guidelines, "Recommended as an option. A number of studies show continuous low-level heat wrap therapy to be effective for treating low back pain. (Nadler-Spine, 2002) (Nadler, 2003) (Lurie-Luke, 2003) (Berliner, 2004) (Lloyd, 2004) One study compared the effectiveness of the Johnson & Johnson Back Plaster, the ABC Warme-Pflaster, and the Procter & Gamble ThermaCare HeatWrap, and concluded that the ThermaCare HeatWrap is more effective than the other two. (Trowbridge, 2004) Active warming reduces acute low back pain during rescue transport. (Nuhr-Spine, 2004) Combining continuous low-level heat wrap therapy with exercise during the treatment of acute low back pain significantly improves functional outcomes compared with either intervention alone or control. (Mayer-Spine, 2005) There is moderate evidence that heat wrap therapy provides a small short-term reduction in pain and disability in acute and sub-acute low-back pain, and that the addition of exercise further reduces pain and improves function." Heat therapy is recommended in acute pain and not for chronic pain, as the injured worker presents with chronic back pain, medical necessity cannot be affirmed.