

Case Number:	CM15-0092972		
Date Assigned:	05/19/2015	Date of Injury:	02/01/2010
Decision Date:	06/18/2015	UR Denial Date:	05/01/2015
Priority:	Standard	Application Received:	05/14/2015

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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, 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 56-year-old female, who sustained an industrial injury on 2/1/10. The injured worker has complaints of neck, back, right shoulder, right elbow and right wrist pain. The documentation noted that examination demonstrated tenderness to palpation over the bilateral paraspinal muscles, bilateral occipital muscles, bilateral suboccipital muscles, bilateral trapezius muscles and bilateral levator scapulae muscles. The diagnoses have included cervical spine strain/sprain with radiculitis; cervical spine discogenic disease; thoracic spine strain and thoracic spine myofascial pain syndrome and right shoulder strain/sprain. Treatment to date has included hot and cold unit to manage pain and reduce swelling; motrin and fexmid. The request was for durable medical equipment (DME) motorized hot and cold unit; medication motrin 600mg #90 and therapy, physical therapy times twelve.

IMR ISSUES, DECISIONS AND RATIONALES

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

DME: motorized hot and cold unit: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, & Hand (Acute & Chronic), Cold/heat packs.

Decision rationale: The claimant has a remote history of a work injury occurring in February 2010 and continues to be treated for neck, back, and right shoulder, elbow, and wrist pain. The claimant continues to work full-time with restrictions. She has a history of gastrointestinal bleeding. When seen, pain was rated at 3-8/10. Physical examination findings included tenderness throughout the cervical and thoracic spine. There was decreased spinal range of motion. Cervical compression testing was positive. There was decreased right shoulder range of motion with positive impingement testing. There was decreased right elbow and wrist range of motion with tenderness. Tinel and Phalen testing was positive. The at-home application of heat or cold packs is recommended. In this case, simple, low-tech thermal modalities would meet the claimant's needs. A motorized hot and cold unit is not medically necessary.

Medication: Motrin 600mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, specific drug list & adverse effects, p68-73 Page(s): 68-73.

Decision rationale: The claimant has a remote history of a work injury occurring in February 2010 and continues to be treated for neck, back, and right shoulder, elbow, and wrist pain. The claimant continues to work full-time with restrictions. She has a history of gastrointestinal bleeding. When seen, pain was rated at 3-8/10. Physical examination findings included tenderness throughout the cervical and thoracic spine. There was decreased spinal range of motion. Cervical compression testing was positive. There was decreased right shoulder range of motion with positive impingement testing. There was decreased right elbow and wrist range of motion with tenderness. Tinel and Phalen testing was positive. Oral NSAIDs (non-steroidal anti-inflammatory medications) are recommended for treatment of chronic persistent pain. Guidelines also recommend an assessment of GI symptoms and cardiovascular risk when NSAIDs are used. In this case, the claimant has a history of gastrointestinal bleeding and prescribing a nonselective NSAID medication such as Motrin without a gastroprotective agent is not medically necessary.

Therapy: physical therapy times twelve: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic pain, Physical medicine treatment. (2) Preface, Physical Therapy Guidelines.

Decision rationale: The claimant has a remote history of a work injury occurring in February 2010 and continues to be treated for neck, back, and right shoulder, elbow, and wrist pain. The

claimant continues to work full-time with restrictions. She has a history of gastrointestinal bleeding. When seen, pain was rated at 3-8/10. Physical examination findings included tenderness throughout the cervical and thoracic spine. There was decreased spinal range of motion. Cervical compression testing was positive. There was decreased right shoulder range of motion with positive impingement testing. There was decreased right elbow and wrist range of motion with tenderness. Tinel and Phalen testing was positive. The claimant is being treated for chronic pain. In terms of physical therapy treatment for chronic pain, guidelines recommend a six visit clinical trial with a formal reassessment prior to continuing therapy. In this case, the number of visits requested is in excess of that recommended. The request is not medically necessary.