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Independent Medical Review
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MAXIMUS Federal Services

Independent Medical Review Final Determination Letter

[redacted]

Dated: 12/27/2013

IMR Case Number:	CM13-0006301	**Date of Injury:**	1/17/2008
Claims Number:	[redacted]	**UR Denial Date:**	7/15/2013
Priority:	Standard	**Application Received:**	8/2/2013
Employee Name:	[redacted]		
Provider Name:	[redacted]		
Treatment(s) in Dispute Listed on IMR Application:	Please see attached for service requested		

DEAR [redacted]

MAXIMUS Federal Services has completed the Independent Medical Review ("IMR") of the above workers' compensation case. This letter provides you with the IMR Final Determination and explains how the determination was made.

Final Determination: PARTIAL OVERTURN. This means we decided that some (but not all) of the disputed items/services are medically necessary and appropriate. A detailed explanation of the decision for each of the disputed items/services is provided later in this letter.

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the Final Determination of the Administrative Director of the Division of Workers' Compensation. This determination is binding on all parties.

In certain limited circumstances, you can appeal the Final Determination. Appeals must be filed with the Workers' Compensation Appeals Board within 30 days from the date of this letter. For more information on appealing the final determination, please see California Labor Code Section 4610.6(h).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations, [redacted]

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Anesthesiology and Pain Managment, has a subspecialty in Acupuncture 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 physician 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.

DOCUMENTS REVIEWED

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- [redacted]
- [redacted]
- [redacted]
- [redacted]

CLINICAL CASE SUMMARY

The physician reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

56 y/o female injured worker who sustained an injury and has been diagnosed with right sided shoulder pain and left sided piriformis syndrome. UR performed on 7/15/13 evaluated clinical documentation, the most recent of which was dated 6/18/13. The most recent medical record available for my review is a note dated 9/10/13.

The clinical issues at hand are whether the left piriformis Botox injection is medically necessary and appropriate, whether the right stellate ganglion block is medically necessary and appropriate, whether the random urine drug screen is medically necessary and appropriate, whether the continue electrical muscle stimulation is medically necessary and appropriate, whether the continue hot/cold unit is medically necessary and appropriate.

IMR DECISION(S) AND RATIONALE(S)

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

1. Left piriformis Botox injection is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Botulinum toxin, which is part of MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, Botulinum Toxin, page 26 which is part of MTUS.

The Physician Reviewer's decision rationale:

In the 9/10/13 note, the provider states: "previously administered botox injections which provider her with more than six months of relief that enabled her to resume her day activities and

exercises. As the effectiveness of botox injections has already been proven in providing satisfactory functional improvement, repeat of this beneficial procedure to attain the same favorable and positive response for chronic low back pain is therefore appropriate."

Prior records do document 6 months of relief from injections (Dr Rosen, on 6/18/13).

As per MTUS citation above, medical necessity is supported for repeat injection if there is a favorable initial response, but only in conjunction with a functional restoration program (FRP). As the injured worker is not currently participating in a FRP, medical necessity is not met. Additionally, treating provider relates that the injured worker had functional improvement, however the specific functional improvement from those injections is not evident in any medical records around the time of the injections.

2. Right stellate ganglion block is medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines for reginal sympathetic blocks, which is part of MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, stellate ganglion block, page 103, which is part of MTUS.

The Physician Reviewer's decision rationale:

MTUS citation above notes "Proposed Indications: This block is proposed for the diagnosis and treatment of sympathetic pain involving the face, head, neck, and upper extremities. Pain: CRPS".

The physician who requested the stellate ganglion block (SGB), Dr [redacted] on 6/18/13 noted "There is allodynia over the right shoulder extending to the right upper arm. No signs of hypersensitivity." In the context of the rest of the report, I think this was an error in communication, as allodynia is noted multiple times throughout the report. Allodynia is a type of hypersensitivity. I believe in the UR determination the assertion that the injured worker does not have hypersensitivity is therefore incorrect, as it appears this was an issue of semantics.

In the 9/10/13 note, the provider states: "The requested treatment was denied by the reviewing physician because there was no hypersensitivity noted and there was no indication of temperature change to the extremity. In the contrary, in my progress reports dated June 20, 2013 and August 9, 2013, under objective findings for the right upper extremity, continued hypersensitivity was clearly noted. Although temperature change was not evident, this does not disqualify her from undergoing such procedure. Since the patient demonstrated some signs and symptoms of complex regional pain syndrome including allodynia and hypersensitivity following right shoulder arthroscopic surgery, the greater is the need for stellate ganglion block for proper diagnosis and prompt therapy. The California Medical Treatment Guidelines, Effective July 18, 2009, page 103, notes that the sympathetic ganglion block is proposed for the diagnosis and treatment of sympathetic pain involving the face, head, neck and upper extremities."

3. Random urine drug screen is not medically necessary and appropriate.

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Opioids, screening for risk of addition (tests), which is part of MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, stellate ganglion block, page 103, which is part of MTUS.

The Physician Reviewer's decision rationale:

Recommended as an option, using a urine drug screen to assess for the use or the presence of illegal drugs, per MTUS citation above.

In the 9/10/13 note, the provider states: "The patient was subjected to urine toxicology screening to monitor her adherence to the prescribed drug regimen. Urine drug testing was also done toevaluate and diagnose substance misuse/abuse, addiction, and/or other aberrant drug induced behavior. According to the California Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines, effective July 18, 2009, affirms that drug testing urine drug screen is recommended as an option assess for the use or the presence of illegal drugs. Urine drug screening was however non certified by Dr[redacted] as there was no documentation that indicate that the patient is on any controlled substance or there is plan to initiate treatment with controlled medication to support this. In response, I would like to point out that urine drug testing is not only indicated for patients who are or will be taking controlled substances; rather, laboratory exam is a critical part of the acute and chronic pain management, especially for my patient with intense and disabling pain, who is highly susceptible to taking non prescription pain medications. Since examination and pure observation are nor reliable to detect anomalies or irregularities, random urine screening is therefore imperative as a preventive strategy to deter any atypical ideations of behaviors. (The ACOEM Guidelines, Second Edition (Revised)."

The use of a urine drug screen for screening to rule out substance abuse is appropriate if planning to prescribe opiate medications. However, the treating provider has not indicated what they would like to screen the injured worker for, nor did they indicate how that may change therapy decisions. The provider notes the injured worker "is highly susceptible to taking non prescription pain medications" because they have "intense and disabling pain". However, the injured worker is not being prescribed opiates now for the intense and disabling pain, and there is no documentation of reasons why this should be withheld (ie, history of addiction). The provider cites ACOEM Guidelines, Second Edition (Revised) Chapter 1 page 4 as the source to corroborate the sentiment that "random urine screening is therefore imperative as a preventive strategy to deter any atypical ideations of behaviors." I respectfully disagree that this source endorsing using urine drug screening as a preventive strategy and deterrant as implied (in someone who is not using opiate medication currently, nor has a history of substance abuse). I believe this is overly broad interpretation of ACOEM's endorsement of the need to prevent medical care utilization and its associated cost. The UDS itself imparts significant cost which does not appear to be medically necessary at this time.

4. Continue electrical muscle stimulation is not medically necessary and appropriate.

The Claims Administrator based its decision on the Official Disability Guidelines, Shoulder, Electrical Stimulation, which is not part of MTUS.

The Physician Reviewer based his/her decision on the Chronic Pain Medical Treatment Guidelines, NMES, page 121, which is part of MTUS.

The Physician Reviewer's decision rationale:

At least one prescription found in the medical records was for a "SurgiStim 4" electrical muscle stimulation device. The MTUS does not comment specifically on this device. MTUS citation above regarding NMES is the closest evidence basis for decision-making in this context for this determination. It states "The scientific evidence related to electromyography (EMG)-triggered electrical stimulation therapy continues to evolve, and this therapy appears to be useful in a supervised physical therapy setting to rehabilitate atrophied upper extremity muscles following stroke and as part of a comprehensive PT program." The injured worker does not have atrophied muscles following a stroke. Overall, the position of the MTUS is that NMES is "not recommended"

5. Continue hot/cold unit is not medically necessary and appropriate.

The Claims Administrator based its decision on the aCOEM Shoulder Chapter (on-line version) regarding cold therapy,w hich is not part of MTUS.

The Physician Reviewer based his/her decision on Initial Approaches to Treatment (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 3) pg 34 which is part of MTUS.

The Physician Reviewer's decision rationale:

Hot/cold unit is not directly addressed by MTUS 2009 Chronic Pain Guidelines.

The 9/10/13 provider note indicates "Regarding hot/cold unit, the reviewing physician denied this unit because there was no rationale provided to indicate why at home application of heat/cold could not be used for symptomatic relief. It should be noted that RICE regimen (Rest, Ice, Compression, and Elevation) is difficult to manage the prolonged application of hot and/or cold and may cause further tissue injury. On that note, hot/cold unit which can safely deliver hours or overnight continuous temperature therapy is preferable. Therefore, to reduce the patients overall symptoms, use of this modality is supported by the ACOEM Guidelines, Second Edition (Revised), in chapter 3 –Initial Approaches to treatment, page 34, which states that the physicians can use passive modalities such as application of heat and cold for temporary amelioration of symptoms and to facilitate mobilixation and graded exercise. They are most effective when the patient uses them at home several times a day."

The text immediately prior to this citation is noted to be "During the acute to subacute phases for a period of 2 weeks or less, physicians can use…" and then goes on to read "can use passive modalities such as application of heat and cold for temporary amelioration of symptoms and to facilitate mobilization and graded exercise.They are most effective when the patient uses them at home several times a day." The injured worker's condition has persisted beyond 2 weeks.

Provider indicates that the device in dispute is indicated partially to "manage the prolonged application of hot and/or cold". However, ACOEM nor MTUS Chronic Pain Guidelines do not affirm the prolonged, chronic use of hot/cold. ACOEM p 203 states "Patients' at-home applications of heat or cold packs may be used before or after exercises" and does not mention prolonged usage.

Above cited ACOEM reference indicates "Self applications of cryotherapies using towels or resusable devices are non-invasive, minimal cost and without complications. Other forms of cryotherapy can be considerably more expensive, including chemicals or cryotherapeutic applications in clinical settings and are not recommended"

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