MAXIMUS Federal Services

Case Number:	CM13-0013952		
Date Assigned:	12/11/2013	Date of Injury:	08/26/1996
Decision Date:	01/30/2014	UR Denial Date:	08/01/2013
Priority:	Standard	Application Received:	08/20/2013

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 Phyiscal Medicine and Rehabilitation, and is licensed to practice in Oklahoma and Texas. 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. 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:

The patient is a 72-year-old female who reported an injury on 8/26/96. The patient is currently diagnosed with right knee medial meniscal tear, right greater trochanteric bursal inflammation, right hand strain, right shoulder impingement syndrome, compensatory left knee pain, compensatory lumbosacral pain secondary to bilateral knee symptomatology, and left shoulder impingement with possible rotator cuff tear. The patient was seen by [redacted] on 5/30/13; she reported aching pain in bilateral shoulders, bilateral wrists, mid and low back pain, and bilateral knees. Physical examination revealed antalgic gait, crepitus in the right shoulder, AC joint tenderness, positive impingement sign, tenderness to palpation of the lumbar spine with spasm and tightness, positive straight leg raising bilaterally, weakness, decreased range of motion of the hip, trochanteric tenderness, medial and lateral joint line tenderness with crepitus of the right knee, and reduced range of motion with weakness.

IMR ISSUES, DECISIONS AND RATIONALES

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

Extracorporeal Shockwave Therapy, right hip: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Cigna's guidelines for extracorporeal shock wave therapy (ESWT) for musculoskeletal conditions (online version), and the Anthem Medical Policy SURG.00045 Extracorporeal Shock Wave Therapy for Orthopedic Conditions.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), EST

Decision rationale: The Official Disability Guidelines state that extracorporeal shockwave therapy is under study for patellar tendinopathy and for long bone hypertrophic non-unions. Extracorporeal shockwave therapy is experimental for a variety of musculoskeletal issues. It is not specifically recommended for the treatment of musculoskeletal pain, including the hip pain present in this case. The medical necessity has not been established. As such, the request is non-certified.

Fluriflex 15/10% Cream, 180gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

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

Decision rationale: The California MTUS Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. As per the clinical notes submitted, there is no evidence of a failure to respond to fist line oral medication prior to the initiation of a topical analgesic. Also, the requested compounded medication contains Flexeril. California MTUS Guidelines state that muscle relaxants are not recommended as there is no evidence for the use of a muscle relaxant as a topical product. Since any compounded product that contains at least one drug that is not recommended is not recommended as a whole, the current request cannot be determined as medically appropriate. As such, the request is non-certified.

TGHot 8/10/2/2/0.05% Cream, 180gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

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

Decision rationale: The California MTUS Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. As per the clinical notes submitted, there is no evidence of a failure to respond to first line oral medication prior to the initiation of a topical analgesic. Furthermore, Gabapentin is not recommended, as there is no peer reviewed literature to support its use, and Capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. Since any compounded product that contains at least one drug that is not recommended is not recommended as a whole, the current request cannot be determined as

medically appropriate. Based on the clinical information received and the California MTUS Guidelines, the request is non-certified.

Home Health Provider, 3 hrs. a day, 3 times a week: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 51.

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

Decision rationale: The California MTUS Guidelines state that home health services are recommended only for patients who are home bound, on a part time or intermittent basis, generally up to no more than 35 hours per week. The patient's provider indicates that a home health aide is necessary to help with house cleaning and simple activities of daily living. However, the California MTUS Guidelines specifically prescribe usage of home health aides to facilitate activities of daily living, noting that the home health services should be limited to that needed for medical purposes. Medical treatment does not include homemaker services like shopping, cleaning, and laundry. Furthermore, there is no evidence of a significant functional deficit that would require the need for home health services. Based on the clinical information received, the request is non-certified.

Gym membership with pool access, 1 year: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Gym Memberships

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Gym Memberships

Decision rationale: The Official Disability Guidelines state that gym memberships are not recommended as a medical prescription unless a home exercise program has not been effective and there is a need for equipment. As per the clinical notes submitted, the patient does not currently meet criteria for a gym membership, as there is no evidence that a home exercise program has been tried and failed. Therefore, the request is non-certified.

Extracorporeal Shockwave Therapy, right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Extracorporeal Shock Wave Therapy (ESWT).

Decision rationale: The Official Disability Guidelines state that extracorporeal shockwave therapy (ESWT) is indicated for patients whose pain is caused by calcifying tendonitis of the shoulder and has remained despite six months of standard treatment. At least three conservative treatments should have been performed prior to the use of ESWT, including rest, ice, NSAIDs, orthotics, physical therapy, and/or injections. As per the clinical notes submitted, the patient does not currently meet criteria for extracorporeal shockwave therapy to the shoulder. Therefore, the request is non-certified.

Medrox Patches: Upheld

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

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

Decision rationale: The California MTUS Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Medrox contains methyl salicylate, menthol, and capsaicin. Capsaicin is recommended only for patients who are intolerant or have not responded to other treatments. As per the clinical notes submitted, there is no indication that this patient has failed to respond to first line oral medication prior to the initiation of a topical analgesic. Based on the clinical information received, the request is non-certified.