MAXIMUS Federal Services

Case Number:	CM13-0024189		
Date Assigned:	11/20/2013	Date of Injury:	05/30/2012
Decision Date:	02/04/2014	UR Denial Date:	08/30/2013
Priority:	Standard	Application Received:	09/13/2013

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 Physical Medicine and Rehabilitation 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.

CLINICAL CASE SUMMARY

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

This 65 year-old female sustained an injury on 5/30/12 while employed by [redacted]. Requests under consideration include Extracorporeal Shock wave Therapy (ESWT) to left shoulder/elbow, IF unit, Acupuncture to left upper extremity/left knee/left hip x 8, Topical Fluriflex 180 gm, and Medrox patches qty. 60. Report dated 7/23/13 from [redacted] noted the patient with complaints of left shoulder, left hip, and left knee pain at 7/10 pain scale. She also complained of left elbow and left wrist pain decreased from 7/10 to 6/10. Exam of left shoulder/arm revealed TTP; unchanged from last visit; restricted ROM; impingement and supraspinatus test positive; Left elbow/forearm showed TTP; unchanged from last visit; Left wrist/hand, left hip, left knee: no changes on neurocirculatory examination. Acupuncture helps in decreasing her pain and tenderness with 10% improvement in function and activities of daily living. Diagnoses were Left shoulder rotator cuff tear (per MRI- pending authorization for left shoulder surgery); Left shoulder strain/sprain; Left elbow strain/sprain; Left elbow lateral epicondylitis; Left forearm strains/sprain and contusion; Left wrist carpal tunnel syndrome exacerbation; s/p left hip contusion; s/p left knee contusion. Treatment plan include continue acupuncture for left upper extremity, left hip, and left knee 2x4; She is prescribed interferential unit; prescribed Fluriflex, Medrox patches, Tramadol. Work status- remained TTD until 9/4/13. Request for acupuncture was partially-certified for 4 visits while the other requests were non-certified on 8/30/13, citing guidelines criteria and lack of medical necessity.

IMR ISSUES, DECISIONS AND RATIONALES

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

Extracorporeal Shock Wave Therapy (ESWT) Left Shoulder and Left Elbow QTY 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-120.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Ankle and Foot Chapter, and Elbow Chapter, 9th Edition, 2014.

Decision rationale: The Official Disability Guidelines recommend extracorporeal shockwave therapy to the shoulder for calcific tendinitus and do not recommend for elbow strain/sprain or epicondylitis as long-term effectiveness has not been evident. Diagnosis includes shoulder impingement and shoulder and elbow strain/sprain with lateral epicondylitis of the elbow. Submitted reports have not adequately demonstrated any diagnosis or clinical findings to support for the ECSW treatment. The Extracorporeal Shockwave Therapy (ESWT) to the left shoulder and left elbow is not medically necessary and appropriate.

Interferential (IF) Unit QTY 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 115-118.

Decision rationale: The MTUS guidelines recommend a one-month rental trial of TENS unit to be appropriate to permit the physician and provider licensed to provide physical therapy to study the effects and benefits, and it should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) as to how often the unit was used, as well as outcomes in terms of pain relief and function; however, there are no documented failed trial of TENS unit or functional improvement such as increased ADLs, decreased medication dosage, increased pain relief or improved work status derived from any transcutaneous electrotherapy to warrant a purchase of an interferential unit for home use for this May 2012 injury. The IF unit is not medically necessary and appropriate.

Acupuncture to the Left Upper Extremity, Left Hip, and Left Knee QTY 8: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265,Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines,Chronic Pain Treatment Guidelines Page(s): 8-9.

Decision rationale: MTUS, Acupuncture Guidelines recommend initial trial of conjunctive acupuncture visit of 3 to 6 treatment with further consideration upon evidence of objective

functional improvement. Submitted reports have not demonstrated the medical indication to support this request. The patient remains totally temporarily disabled from acupuncture treatment already rendered for this May 2012 injury with unchanged pain symptoms and clinical findings of tenderness. The Acupuncture for the Left upper extremity, Left hip, and Left knee quantity 8 is not medically necessary and appropriate.

Fluriflex 180gm Topical QTY 1: 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 Topical Analgesics Page(s): 111-113.

Decision rationale: Per MTUS Chronic Pain Guidelines, the efficacy in clinical trials for topical analgesic treatment modality has been inconsistent and most studies are small and of short duration. These medications may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. There is little evidence to utilize topical analgesic Fluriflex over oral NSAIDs or other pain relievers for a patient without contraindication in taking oral medications. Submitted reports have not adequately demonstrated the indication or medical need for this topical analgesic. Fluriflex 180 gm topical is not medically necessary and appropriate.

Medrox Patches QTY 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113. Decision based on Non-MTUS Citation ODG Web, 2004, Chronic Pain, Topical Analgesics

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

Decision rationale: Per MTUS Chronic Pain Guidelines, the efficacy in clinical trials for topical analgesic treatment modality has been inconsistent and most studies are small and of short duration. These medications may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. There is little evidence to utilize topical analgesic Medrox over oral NSAIDs or other pain relievers for a patient without contraindication in taking oral medications. Submitted reports have not adequately demonstrated the indication or medical need for this topical analgesic.There is little to no research to support the use of many of these topical agents and any compounded product that contains at least one drug or drug class that is not recommended is not recommended. Medrox Patches QTY 60 is not medically necessary and appropriate.