

Case Number:	CM13-0043854		
Date Assigned:	12/27/2013	Date of Injury:	06/18/2012
Decision Date:	02/24/2014	UR Denial Date:	10/10/2013
Priority:	Standard	Application Received:	10/25/2013

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 & Rehabilitation, has a subspecialty in Pain Management 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. 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:

This patient reported a date of injury of June 18, 2012. A utilization review determination dated October 10, 2013 recommends non-certification of physical therapy 2 x 6 weeks to both the right shoulder and wrist, TENS unit 30 day trial, Ultram 50mg po 1-2 every 6 hours as needed, and Theraflex cream. The previous reviewing physician recommended non-certification of physical therapy 2 x 6 weeks to both the right shoulder and wrist due to lack of documentation of the number of visits completed to shoulder and wrist and corresponding functional improvement; non-certification of TENS unit 30 day trial due to lack of documentation of the patient's treatment history and a specific duration or request for a trial; non-certification of Ultram 50mg po 1-2 every 6 hours as needed due to lack of documentation of an opioid utilization timeline, the domains of ongoing opioid management, including monitoring for diversion, abuse, side effects, or tolerance development, dosage adjustments, attempts to wean and taper, endpoints of treatment, and continued compliance; and non-certification of Theraflex cream due to lack of documentation of compelling circumstances identifying why the requested compound topical would be required despite adverse evidence. A PR-2 report dated September 9, 2013 identifies Subjective Complaints of pain that affects her right shoulder and right wrist. She has been taking Ultram. She has been using Theraflex cream. She reports improvement in her pain level from 6/10 to 3/10 on a pain scale of 0 to 10 after medications. She has completed 12 sessions of physical therapy which helped to relieve her symptoms. Objective findings include limited range of motion with flexion to 150 degrees, abduction 150 degrees and internal rotation of 60 degrees. There was tenderness noted over the acromioclavicular joint. There was painful arc of motion noted beyond 135 degrees. Examination of the right wrist revealed limitation of motion with flexion noted to be 50

IMR ISSUES, DECISIONS AND RATIONALES

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

physical therapy 3 x 6 weeks to both right shoulder and wrist: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 200, 265. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder chapter, Physical Therapy and Carpal Tunnel Syndrome, Physical Therapy.

Decision rationale: Regarding the request for physical therapy 3 x 6 weeks to both right shoulder and wrist, Occupational Medicine Practice Guidelines state a physical therapist can serve to educate the patient about an effective exercise program. ODG recommends occupational/physical therapy in the management of carpal tunnel syndrome. ODG additionally recommends an initial trial of physical therapy; and then with documentation of objective functional improvement, ongoing objective treatment goals, as well as a statement indicating why an independent program of the home exercise would be insufficient to address any remaining deficits, additional therapy may be indicated. For the postoperative treatment of carpal tunnel syndrome, ODG recommends 3-8 visits over 3-5 weeks and for the treatment of impingement/rotator cuff tear 10 visits over 8 weeks. Within the medical information made available for review, the patient is noted to have had improvement with previous therapy. However, it is also noted that the patient has undergone 12 previous therapy visits, which exceeds Guidelines recommendations. There is no documentation of a statement indicating why an independent program of the home exercise would be insufficient to address any remaining deficits. As such, the current request for physical therapy 3 x 6 weeks to both right shoulder and wrist is not medically necessary.

TENS unit, 30 day trial: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-117.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-117.

Decision rationale: Regarding the request for TENS unit, 30 day trial, Chronic Pain Medical Treatment Guidelines Criteria includes: Documentation of pain of at least three months duration; There is evidence that other appropriate pain modalities have been tried (including medication) and failed; A one-month trial period of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; rental would be preferred over purchase during this trial; Other ongoing pain treatment should also be documented during the trial period including medication usage; A treatment plan including the

specific short- and long-term goals of treatment with the TENS unit should be submitted. Within the medical information made available for review, there is evidence that other appropriate pain modalities have been tried. However, given that there are associated requests for therapy and medication, it is not clear that these modalities have failed. Additionally, no treatment plan including the specific short- and long-term goals of treatment with the TENS unit has been submitted. In the absence of such documentation, the currently requested TENS unit, 30 day trial is not medically necessary.

Ultram 50mg po 1-2 every 6 hours: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 81.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 75-79.

Decision rationale: Regarding the request for Ultram 50mg po 1-2 every 6 hours as needed, California Pain Medical Treatment Guidelines state that Ultram is a short acting opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is indication that the Ultram is improving the patient's pain. However, there is no documentation regarding side effects and no discussion regarding aberrant use. In the absence of such documentation, the currently requested Ultram 50mg po 1-2 every 6 hours as needed is not medically necessary.

Theraflex cream: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain chapter, Herbal Medicines.

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

Decision rationale: Regarding the request for Theraflex cream, Chronic Pain Medical Treatment Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The Guidelines also state there is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Within the medical information made available for review, there is documentation of neuropathic pain. However, there is no documentation that trials of antidepressants and anticonvulsants have failed. In the absence of such documentation, the currently requested Theraflex cream is not medically necessary.

