

Case Number:	CM13-0056372		
Date Assigned:	12/30/2013	Date of Injury:	02/15/2011
Decision Date:	06/16/2014	UR Denial Date:	10/18/2013
Priority:	Standard	Application Received:	11/22/2013

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. The expert reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in Oklahoma, Texas, California and Tennessee. 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/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 59 year old female whose date of injury is 02/15/2012. Orthopedic surgery consultation dated 10/22/13 indicates that the patient lifted a 30 pound box of cake and felt a sudden pop along with pain in her bilateral shoulders, bilateral arms and bilateral wrists. The patient's last day of work was 02/15/12. The patient completed 6 sessions of physical therapy in 2012. The patient is reportedly scheduled for right shoulder surgery on 10/30/13. Medications are listed as Prozac, Metformin, ibuprofen, hydrochloride and Atenolol. The patient specifically denied gastrointestinal problems. The patient specifically denied symptoms of seizures, memory loss, tremors, blackouts, paralysis, stroke, headaches or other neurological problems. On physical examination there is no tenderness to palpation of the paraspinal musculature. Spurling test is negative bilaterally. Range of motion of the bilateral shoulders is full. Provocative testing is negative. Bilateral elbow range of motion is full. Bilateral wrist range of motion is full. The patient has tenderness along the triangular fibrocartilage region of the bilateral wrists. Provocative testing of the wrists is negative. Strength is rated as 5/5 throughout. There is a normal neurologic exam of the upper extremities. Sensation is intact. MRI of the left wrist dated 12/06/13 revealed linear signal in the distal ulna most likely sequelae of old injury without any associated marrow edema; no tendinous tear is seen; partial tear of the triangular fibrocartilage. MRI of the right wrist dated 12/06/13 revealed findings which may represent a mass versus a tendon tear; partial tear of the triangular fibrocartilage; osteoarthritic changes of the first carpometacarpal joint.

IMR ISSUES, DECISIONS AND RATIONALES

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

ORTHOSTIM INTERFERENTIAL UNIT FOR ONE MONTH: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
INTERFERENTIAL CURRENT STIMULATION (ICS) Page(s): 118-120.

Decision rationale: Based on the clinical information provided, the request for Orthostim interferential unit for one month is not recommended as medically necessary. CA MTUS guidelines note that interferential stimulation is not recommended as an isolated intervention. There is no documentation that the patient's pain is ineffectively controlled with medications. There is no indication that the patient has undergone any recent active treatment. There are no specific, time-limited treatment goals provided. There is very limited support for interferential therapy in CA MTUS guidelines. The request is not medically necessary or appropriate.

STERILE FOAM ELECTRODES, ONE PACK: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

NON-STERILE 2" ROUND ELECTRODES, 3 PACKS: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

LEAD WIRE: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

POWER PACK TIMES 12: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

ADHESIVE REMOVER TOWELS QTY: 16.00: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**RIGHT SHOULDER SHOCKWAVE THERAPY ONCE A WEEK FOR 3 WEEKS:
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).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) SHOULDER, EXTRACORPOREAL SHOCK WAVE THERAPY (ESWT)

Decision rationale: Based on the clinical information provided, the request for right shoulder shockwave therapy once a week for 3 weeks is not recommended as medically necessary. The Official Disability Guidelines (ODG) support shockwave therapy for patients with calcifying tendinitis who have failed six months of at least 3 conservative treatments. The submitted records fail to provide a comprehensive assessment of treatment completed to date or the patient's response thereto. The submitted records fail to establish the presence of calcifying tendinitis. The request is not medically necessary or appropriate.

BILATERAL WRIST BRACES: Upheld

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

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 AND HAND, IMMOBILIZATION (TREATMENT)

Decision rationale: Based on the clinical information provided, the request for bilateral wrist braces is not recommended as medically necessary. The Official Disability Guidelines recommend bracing for displaced fractures which is not documented in this case. Immobilization and rest appear to be overused as treatment. Early mobilization benefits include earlier return to work; decreased pain, swelling, and stiffness; and a greater preserved range of joint motion, with no increased complications. There is no clear rationale provided to support bilateral wrist braces at this time. The request is not medically necessary or appropriate.

NEUROLOGY CONSULTATION FOR HEADACHE: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM OCCUPATIONAL MEDICINE PRACTICE GUIDELINES SECOND EDITION, CHAPTER 7, 127

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE (ACOEM), 2ND EDITION, (2004), CHAPTER 7, 127

Decision rationale: Based on the clinical information provided, the request for neurology consultation for headache is not recommended as medically necessary. Per note dated 10/22/13, the patient specifically denied symptoms of seizures, memory loss, tremors, blackouts, paralysis, stroke, headaches or other neurological problems.

INTERNAL MEDICINE CONSULTATION FOR BLOOD PRESSURE AND DIABETES:
Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 7, Consultation Section, page 127.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE (ACOEM), 2ND EDITION, (2004), CHAPTER 7, 127

Decision rationale: Based on the clinical information provided, the request for internal medicine consultation for blood pressure and diabetes is not recommended as medically necessary. Per note dated 10/22/13, the patient reports having high blood pressure, but it is controlled with medication. The patient also reports having diabetes and high cholesterol, but it is controlled with medication. The request is thus not medically necessary or appropriate.

HAND SPECIALIST CONSULTATION: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 7, Consultation Section, page 127.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE (ACOEM), 2ND EDITION, (2004), CHAPTER 7, 127

Decision rationale: Based on the clinical information provided, the request for hand specialist consultation is not recommended as medically necessary. There is no clear rationale provided to support the requested consultation at this time, and therefore medical necessity is not established.

LUMBAR EPIDURAL STEROID INJECTION: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines EPIDURAL STEROID INJECTIONS Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines EPIDURAL STEROID INJECTIONS Page(s): 46.

Decision rationale: Based on the clinical information provided, the request for lumbar epidural steroid injection is not recommended as medically necessary. There is no comprehensive assessment of treatment completed to date or the patient's response thereto submitted for review. The patient's physical examination fails to establish the presence of active lumbar radiculopathy, and there are no imaging studies/electrodiagnostic results submitted for review. The request is nonspecific and does not indicate the level, laterality or approach to be performed.