

Case Number:	CM13-0067594		
Date Assigned:	01/03/2014	Date of Injury:	12/14/2012
Decision Date:	06/12/2014	UR Denial Date:	12/02/2013
Priority:	Standard	Application Received:	12/18/2013

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in 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 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 injured worker is a 50-year-old female who reported an injury on 12/14/2012. The mechanism of injury was not stated. Current diagnoses include bilateral shoulder par scapular strain, bilateral sprain of the elbow, bilateral wrist sprain, and bilateral knee sprain with patellofemoral arthralgia. The injured worker was evaluated on 12/24/2013. The injured worker reported bilateral knee pain and swelling. Current medications include Tylenol No. 4, Flexeril, and Motrin. Physical examination revealed postoperative scars in the right shoulder, bilateral knee tenderness to palpation, crepitus, and positive grind testing. Treatment recommendations included continuation of current medication.

IMR ISSUES, DECISIONS AND RATIONALES

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

EXTRACORPOREAL SHOCKWAVE THERAPY TO THE RIGHT ELBOW: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 235.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 24-25. Decision based on Non-MTUS Citation MTUS American College Of Occupational And Environmental Medicine (ACOEM), 2nd Edition, (2004), elbow disorders and the Official Disability Guidelines (ODG), Elbow Chapter, Extracorporeal Shockwave Therapy (ESWT).

Decision rationale: The California MTUS/ACOEM Practice Guidelines state there are no quality studies on treating sprains of the elbow. Official Disability Guidelines do not recommend high energy extracorporeal shockwave therapy, but recommend low energy extracorporeal shockwave therapy for better outcomes without the need for anesthesia. There is no mention of previous conservative treatment for the elbow. There is also no frequency or quantity listed in the current request. Therefore, the request is not medically necessary.

TYLENOL #4, QTY: 120: 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): 35.

Decision rationale: The California MTUS Guidelines state codeine is recommended as an option for mild to moderate pain. It is used as a single agent or in combination with acetaminophen and other products for treatment of mild to moderate pain. The injured worker has utilized Tylenol No. 4 since at least 10/2013. There is no documentation of objective functional improvement. There is also no frequency listed in the current request. As such, the request is not medically necessary.

ROBAXIN 750MG, #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66.

Decision rationale: The California MTUS Guidelines state muscle relaxants are recommended as non-sedating second line options for short term treatment of acute exacerbations. The injured worker currently utilizes Flexeril 10 mg. There is no indication that this injured worker currently utilizes Robaxin 750 mg. There is also no frequency listed in the current request. Therefore, the request is not medically necessary.

ZOFRAN ODT 8MG, #10: 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), Pain Chapter, Antiemetics.

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

Decision rationale: The Official Disability Guidelines state ondansetron is not recommended for nausea and vomiting secondary to chronic opioid use. Zofran has been FDA approved for nausea and vomiting secondary to chemotherapy and radiation treatment. Therefore, the injured worker does not meet criteria for the requested medication. As such, the request is not medically necessary.