

Case Number:	CM13-0068831		
Date Assigned:	01/03/2014	Date of Injury:	04/28/2004
Decision Date:	06/05/2014	UR Denial Date:	11/26/2013
Priority:	Standard	Application Received:	12/19/2013

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 Interventional Spine 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 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 45 year old female with date of injury 4/28/04. The treating physician report dated 11/16/14 indicates that the patient presents with worsening of right shoulder and forearm pain due to increased workload. The current diagnoses are: Inter-current exacerbation of repetitive strain injury, Scapulothoracic MPS with partial response to myofascial release, Left pronator syndrome, Rule out right radial tunnel syndrome. The utilization review report dated - 11/26/13 denied the request for acupuncture 6 visits, DME purchase H-Wave and Voltaren gel based on lack of guideline support.

IMR ISSUES, DECISIONS AND RATIONALES

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

ACUPUNCTURE QTY 6.00: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The patient presents with worsening of right shoulder pain and forearm pain due to increased lifting, grasping and pushing/pulling. The current request is for the DME purchase of one H-Wave unit. Review of the 7/24/13 physician's report states the patient has not

received her trial of H-Wave unit. By 8/8/13 report, the patient "Had responded to H-wave rental unit and continues to be in need of purchase H-Wave unit." The 11/6/13 report states, "Continues to be in need of purchase H-Wave unit." The provider does not provide discussion regarding the use and functional benefit. It is merely documented that the patient has responded. MTUS supports a home unit if one-month trial has been successful in conjunction with a functional restoration approach and if pain and functional improvements are documented. In this case, there is lack of such documentation, particularly any discussion regarding the patient's functional response to a home H-wave unit. Recommendation is for denial.

DME PURCHASE-H-WAVE UNIT QTY 1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H-WAVE STIMULATION Page(s): 117-118.

Decision rationale: The patient presents with worsening of right shoulder pain and forearm pain due to increased lifting, grasping and pushing/pulling. The current request is for the DME purchase of one H-Wave unit. Review of the 7/24/13 physician's report states the patient has not received her trial of H-Wave unit. By 8/8/13 report, the patient "Had responded to H-wave rental unit and continues to be in need of purchase H-Wave unit." The 11/6/13 report states, "Continues to be in need of purchase H-Wave unit." The provider does not provide discussion regarding the use and functional benefit. It is merely documented that the patient has responded. MTUS supports a home unit if one-month trial has been successful in conjunction with a functional restoration approach and if pain and functional improvements are documented. In this case, there is lack of such documentation, particularly any discussion regarding the patient's functional response to a home H-wave unit. Recommendation is for denial.

VOLTAREN GEL #100 GRAMS TIMES TWO REFILLS QTY 3.00: Overturned

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

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

Decision rationale: The patient presents with worsening of right shoulder pain and forearm pain due to increased lifting, grasping and pushing/pulling. The current request is for Voltaren Gel #100g x 2 refills quantity 3. The treating physician documents a repetitive strain injury affecting the right shoulder, elbow and forearm. The MTUS guidelines support topical NSAIDs such as Voltaren as they are, "Indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist)." It is also supported for tendinitis, which this patient appears to suffer from. Recommendation is for authorization.