

Case Number:	CM14-0009830		
Date Assigned:	02/21/2014	Date of Injury:	12/31/2012
Decision Date:	07/07/2014	UR Denial Date:	12/30/2013
Priority:	Standard	Application Received:	01/23/2014

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 and is licensed to practice in Minnesota. 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 with reported dates of injury from 12/31/2011 to 12/31/2012. The mechanism of injury was not submitted within the medical profile. Her diagnoses were noted to include cervical spine musculoligamentous sprain/strain with radiculitis, lumbar spine musculoligamentous sprain/strain with radiculitis, left shoulder sprain/strain and parascapular tendinosis, impingement syndrome, rotator cuff tear, bilateral wrist sprain/strain and chronic overuse syndrome, left wrist carpal tunnel syndrome, bilateral wrist ulnar nerve entrapment, bilateral knee sprain/strain, bilateral ankle sprain/strain, abdominal pain, and improved sleep disturbance. Her previous treatments included acupuncture, pain medications, and physical therapy. The physical examination performed on 01/16/2013 reported the range of motion of the cervical spine was normal in all directions. There was some tenderness and spasm on palpation of the paracervical musculature bilaterally and over the left trapezius muscles. The provider reported the compression and distraction tests were negative and examination of the left shoulder revealed anterior, posterior, clavicle, biceps muscle, and bicipital tendon groove tenderness, tenderness over parascapular area of the medial border, decreased range of motion, and negative impingement, drop arm, supraspinatus, Yergason's, and apprehension tests. The progress note also reported examination of the wrists revealed dorsal and palmar tenderness, normal range of motion, and positive Phalen's, Tinel's, and Finkelstein's tests bilaterally. The report also stated grip strength was decreased in the hands, and full range of motion was noted bilaterally in the elbows and hands. The injured worker reported pain in the neck, mid/upper back, lower back, left shoulder/arm, bilateral knees, and bilateral ankles/feet. The injured worker reported complaints of pain and numbness in the bilateral wrists/hands. The provider reported, on the pain scale, the pain in the neck and left wrist/hand is rated 7/10, which is increased from 6/10; on the last visit it was 6/10 in the mid/upper back, which has remained the same since her

last visit; 4/10 in the lower back and bilateral ankles/feet, which has remained the same since her last visit; 8/10 in the left shoulder/arm, which has increased from 4/10 to 7/10 on her last visit; 6/10 in the right wrist/hand, which has decreased from 7/10 on the last visit; and 4/10 in the bilateral knees, which has increased from 3/10 on the last visit. The progress note reported the injured worker stated the acupuncture did not help, but physical therapy did, and requested to get some additional physical therapy for her cervical spine and left shoulder. The Request for Authorization Form dated 01/03/2014 is for Flurflex 180 grams as needed and TGHOT 180 grams as needed, and the physician's rationale was not submitted within the medical records. The request is for referral of extracorporeal shockwave therapy of bilateral wrists and left shoulder; the provider's rationale is not submitted within the medical records. The request is for a purchase of a paraffin bath; the provider's rationale was not submitted within the medical records. The request is for a hot and cold unit, the provider's rationale was not submitted within the medical records.

IMR ISSUES, DECISIONS AND RATIONALES

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

REFERRAL FOR EXTRACORPOREAL SHOCKWAVE THERAPY FOR THE BILATERAL WRISTS AND LEFT SHOULDER: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Extracorporeal shockwave therapy.

Decision rationale: The injured worker has full range of motion to her wrists, and the left shoulder was decreased in range of motion. The MTUS/ACOEM Guidelines indicate that high energy extracorporeal shockwave therapy is for calcifying tendinitis of the shoulder. The Official Disability Guidelines recommend extracorporeal shockwave therapy for calcifying tendinitis, but not for other shoulder disorders. The criteria for the use of extracorporeal shockwave therapy are for injured workers who have pain from calcifying tendinitis of the shoulder that has remained despite extensive standard treatment that includes three (3) conservative treatments that have been performed prior to the use of extracorporeal shockwave therapy, and this would include rest, ice, non-steroidal anti-inflammatory drugs (NSAIDs), orthotics, physical therapy, and injections. The injured worker does not have a diagnosis of calcifying tendinitis. Therefore, the request for shockwave therapy is not warranted and the guidelines do not have evidence to support the use of shockwave therapy to the wrists. Therefore, the request is not medically necessary.

PURCHASE OF PARAFFIN BATH: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: The documentation does not provide the part of the body for paraffin bath use. The Chronic Pain Guidelines indicate that passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are targeted at controlling symptoms such as pain, inflammation, and swelling, and to improve the rate of healing of soft tissue injuries. The guidelines also state the use of active treatment modalities, such as exercise, education, activity modification instead of passive treatments is associated with substantially better clinical outcomes. The most recent progress note noted that the injured worker was beginning physical therapy and possibly going to have surgery, and the guidelines do not recommend passive modalities for the treatment of pain. Additionally, the request does not specify what part of the body to use with the paraffin bath. Therefore, the request is not medically necessary.

HOT AND COLD UNIT: 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: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 337. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

Decision rationale: The request does not state what part of the body is to use the cold and unit. The MTUS/ACOEM Guidelines indicate that applications of hot heat or cold packs may be used before or after exercises and are as effective as those performed by therapists. The Official Disability Guidelines recommend cold/hot packs as an option for acute pain. The guidelines state that at home local applications of cold packs in the first few days of acute complaint; thereafter, applications of heat packs or cold packs. The evidence for the application of cold treatment to low back pain is more limited than heat therapy, with only three (3) poor quality studies located as supporting its use, but studies confirmed that it may be a low risk, low cost option. There is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful in pain reduction and return to normal function. The guidelines do not recommend the hot and cold unit, and the guidelines do not have evidence to support the use of cold therapy. Therefore, the request is not medically necessary.

FLURIFLEX 180 GM: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-114.

Decision rationale: The injured worker has been using this medication for pain. The Chronic Pain Guidelines indicate that topical analgesics are largely experimental in use with few

randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The guidelines state any compounded product that contains at least one (1) drug or drug class that is not recommended is not recommended. The guidelines state that there is no evidence for the use of any muscle relaxant as a topical product. The compound, Flurflex, contains flurbiprofen 15% and cyclobenzaprine 10%, and cyclobenzaprine, and is a drug that is not recommended in a topical form by the guidelines. Additionally, the request failed to provide the frequency for which this medication is being utilized. Therefore, the request is not medically necessary.

TGHOT 180 GM: Upheld

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): 111-114.

Decision rationale: TGHOT contains tramadol/Gabapentin/menthol/camphor/capsaicin. The injured worker has been using this medication for pain. The Chronic Pain Guidelines indicate that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The guidelines state topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The guidelines also state any compounded product that contains at least one (1) drug or drug class that is not recommended is not recommended. Gabapentin is not recommended for topical analgesics, there is no peer-reviewed literature to support the use. Additionally, the request failed to provide the frequency at which the medication is utilized. Therefore, the request is not medically necessary.