

Case Number:	CM14-0109233		
Date Assigned:	08/01/2014	Date of Injury:	02/05/2014
Decision Date:	08/29/2014	UR Denial Date:	06/16/2014
Priority:	Standard	Application Received:	07/14/2014

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 Illinois. 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 42-year-old male who reported an injury 02/05/2014 reportedly, he was a truck driver and his truck rolled over on a turn. He sustained injuries to his shoulder, right ribs, right side, neck, and right leg. The injured worker's treatment history included medications, x-rays, urine drug screen. The injured worker was evaluated on 02/10/2014 and it was documented that the injured worker's condition had not improved significantly. The injured worker complained of lower back pain that was described as sharp, and pain level was a 10/10; frequency was constant. The injured worker complained of shoulder pain that was 8/10 that was described as sharp and extremely severe. Physical examination of the right shoulder revealed there was no tenderness on the right sternal clavicular and acromioclavicular joint. There were muscle spasm of the right trapezius, deltoid upper extremity muscles. There was restricted range of motion on the right shoulder, flexion was 100/180 degrees, internal rotation was 40/90 degrees, and abduction was 100/180 degrees. There was no weakness of the right extremities. Medications included etodolac ER 600 mg, omeprazole, 20 mg, orphenadrine citrate ER 100 mg, tramadol HCL 50 mg, hydrocodone/acet 5/325 mg. Diagnoses included sprain/strain lumbar, pain in neck, sprain/strain cervical, muscle spasm in neck, sprain/strain shoulder right, and contusion chest wall. The Request for Authorization or rationale were not submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Aquatic therapy 2x week X 6 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic therapy Page(s): 22.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic Therapy & Physical Medicine Page(s): page(s) 22& 98-99.

Decision rationale: The requested is non-certified. The CA MTUS Chronic Pain Medical Treatment Guideline recommends aqua therapy as an optional form of exercise therapy, where available as alternative to land based physical therapy. Aquatic therapy (including swimming) can minimize the effects of gravity so it is especially recommended when reduced weight bearing is desirable, for example, extreme obesity. Physical medicine guidelines recommend a total of 9-10 visits over 8 weeks for myalgia and myositis, and 8-10 visits over 4 weeks for neuralgia, neuritis, and radiculitis. There was lack of documentation of outcome measurements if the injured worker has not participated in physical therapy sessions. In addition, the request failed to indicate what location of the body is requiring Aquatic Therapy. Given the above, request for aquatic therapy 2 times a week X weeks is non-certified.

Injection of right shoulder 80mg kenalog/20mg marcin: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205.

Decision rationale: The requested is non-certified. According to the California MTUS/ACOEM state shoulder complaints invasive techniques have limited proven value. If pain with elevation significantly limits activities, a subacromial injection of local anesthetic and a corticosteroid preparation may be indicated after conservative therapy (i.e., strengthening exercises and nonsteroidal anti-inflammatory drugs) for two to three weeks. The evidence supporting such an approach is not overwhelming. The total number of injections should be limited to three per episode, allowing for assessment of benefit between injections. Some small studies have supported using acupuncture, but referral is dependent on the availability of experienced providers with consistently good outcomes. The guidelines recommends corticosteroid injections for individuals with impingement syndrome or tendinitis of the shoulder. The provider failed to indicate a medical necessity of the corticosteroid injection consisting of Kenalog and Marcin. The provider failed to indicate VAS outcome measurements after injured worker takes pain medications. Give the above, the request for injection of right shoulder 80 mg kenalog/20mg Marcin is non-certified.