

Case Number:	CM14-0013179		
Date Assigned:	03/26/2014	Date of Injury:	11/05/2001
Decision Date:	07/29/2014	UR Denial Date:	01/22/2014
Priority:	Standard	Application Received:	02/03/2014

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 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 underlying date of injury in this case is 11/05/2001. The treating diagnoses include cervical sprain with possible cervical radiculopathy, right shoulder impingement syndrome with partial-thickness rotator cuff tear, right elbow pain, and right wrist sprain/strain. On 11/27/2013, the primary treating orthopedic surgeon saw the patient in initial comprehensive orthopedic evaluation. The patient's injury from 2001 was noted when the patient was pulling a cart full of trash bags and was pulling the cart with her right hand and her arm was extended behind her and the handle of the cart broke off. The treating physician planned to obtain prior medical records including cervical and shoulder MRI imaging of December 2007; in order to accurately assess the patient's condition and future medical treatment needs. The treating provider also prescribed a topical cream and Naprosyn and recommended an interferential unit, right wrist brace and planned further follow-up.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy treatment for the right shoulder/elbow/wrist, quantity 12: Upheld

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

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

Decision rationale: The California MTUS Chronic Pain Medical Treatment Guidelines, section on physical medicine, recommends transition to independent active home rehabilitation. This patient would be anticipated to have previously transitioned to an independent home rehabilitation program. The medical records indicate that there may have been extenuating circumstances in this regard given that the patient's prior treatment was in an incarceration setting. That said, it would be appropriate to review the patient's past physical therapy program and past treatment before determining current treatment goals for this chronic injury. Therefore, the request physical therapy treatment for the right shoulder, elbow, and wrist, quantity 12 is not medically necessary and appropriate.

Prescription of Cyclo/Keto/Lido Cream 240 gm, #2: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory Medications Page(s): 22.

Decision rationale: The California MTUS Chronic Pain Medical Treatment Guidelines recommends use of topical analgesics only if there is a specific discussion of the rationale and proposed mechanism of action of this treatment. The records do not provide such details regarding this current request. Additionally, Cyclobenzaprine is specifically not recommended for topical use by these guidelines. Ketoprofen is also not recommended for topical use given a FDA advisory for possible photocontact dermatitis. For these multiple reasons, the request for Cyclo/Keto/Lido Cream 240 gm, #2 is not medically necessary and appropriate.

Prescription of Naproxen 550 mg, #120: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Nsaids (Non-Steroidal Anti-Inflammatory Drugs) Page(s): 67-73.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-inflammatory medications Page(s): 22.

Decision rationale: The MTUS section on anti-inflammatory medications, state that anti-inflammatories are the traditional first-line treatment to reduce pain so activity and functional restoration can resume. This medication is appropriate for ongoing management of a chronic musculoskeletal condition if benefit is reported by the patient. The treatment guidelines do not indicate that anti-inflammatory medications are only for short-term use, and these guidelines do not indicate that only osteoarthritis is an acceptable diagnosis for anti-inflammatory medications. For these reasons, the request for Naproxen 550 mg # 120 is medically necessary and appropriate.

Electromyogram (EMG) of the bilateral upper extremities, quantity 1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

Decision rationale: The MTUS/ACOEM Guidelines recommends electromyography and nerve conduction velocities to help identify subtle focal neurological dysfunction in patients with neck or arm symptoms. Implicit in this guideline is that a detailed history and physical exam and differential diagnosis should be documented. Therefore, the request for EMG of the bilateral upper extremities, quantity 1 is not medically necessary and appropriate.

Nerve conduction study (NCS) of the right upper extremity quantity 1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

Decision rationale: The MTUS/ACOEM Guidelines, chapter 8/neck, recommends electromyography and nerve conduction velocities to help identify subtle focal neurological dysfunction in patients with neck or arm symptoms. Implicit in this guideline is that a detailed history and physical exam and differential diagnosis should be documented. It would be appropriate to first review the patient's past medical records before determining if an electrodiagnostic study is indicated and to help formulate a differential diagnosis for such a study. For these reasons, the request for NCS of the right upper extremity, quantity 1 is not medically necessary and appropriate.

Nerve Conduction Study (NCS) of the left upper extremity, quantity 1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

Decision rationale: The MTUS/ACOEM Guidelines, chapter 8/neck, recommends electromyography and nerve conduction velocities to help identify subtle focal neurological dysfunction in patients with neck or arm symptoms. Implicit in this guideline is that a detailed history and physical exam and differential diagnosis should be documented. It would be appropriate to first review the patient's past medical records before determining if an electrodiagnostic study is indicated and to help formulate a differential diagnosis for such a study. For these reasons, the request for NCS of the left upper extremity, quantity 1 is not medically necessary and appropriate.

Extracorporeal shockwave therapy for the right elbow, quantity 1: 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), Elbow, Extracorporeal Shockwave Therapy.

Decision rationale: The Official Disability Guidelines Elbow chapter discusses extracorporeal shockwave therapy and concludes that this treatment is not recommended. The medical records do not provide a specific alternative rationale or indication for this treatment. Therefore, the request for extracorporeal shockwave therapy for the right elbow, quantity 1 is not medically necessary and appropriate.

Acupuncture treatment for the right shoulder/elbow/wrist, quantity 12: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The California MTUS Acupuncture Guidelines, states that acupuncture may be an option to hasten functional recovery. The MTUS guideline indicates that the time to produce initial functional improvement is 3-6 treatments. Therefore, the current request for 12 acupuncture visits exceeds the treatment guidelines. The request for acupuncture treatment for the right shoulder, elbow, and wrist quantity 12 is not medically necessary and appropriate.