

Case Number:	CM14-0056210		
Date Assigned:	07/02/2014	Date of Injury:	05/17/2011
Decision Date:	08/01/2014	UR Denial Date:	03/25/2014
Priority:	Standard	Application Received:	04/15/2014

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, 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 44-year-old female with date of injury of 05/17/2011. The listed diagnoses per [REDACTED] are: Right shoulder impingement syndrome with tendinitis/bursitis. Status post right elbow lateral epicondylitis release 07/11/2013 and carpal tunnel release with residuals. According to this report, the patient complains of right elbow pain with swelling. The pain increases with lifting, carrying, gripping, grasping, pushing, pulling, torqueing, and squeezing. She also complains of right wrist pain with swelling, numbness, and tingling into the fingers. The pain increases with lifting, carrying, gripping, grasping, pushing, pulling, torqueing, and squeezing. The physical exam shows the patient is well nourished well developed, in no apparent distress. The bilateral shoulders reveals tenderness to palpation over the anterior and lateral deltoid, bicep tendon, acromioclavicular joint, and anterior and lateral acromion on the right. Impingement test, Neer's test, Hawkins' test, and empty can supraspinatus tests are all positive on the right. Range of motion of the shoulder is diminished on the right and intact on the left. The right elbow shows tenderness to palpation over the ECRB and lateral epicondyle on the right. Right elbow incision is well healed. Range of motion of the elbow is within normal range. The right wrist and hand shows a well-healed incision. Phalen's sign, Tinel's sign, and compression tests are all negative on the right. Range of motion of the wrist is within normal limits. Dermatome testing reveals intact sensation to pinprick and light touch throughout the bilateral upper extremities. Myotomes all tested 5/5 throughout the bilateral upper extremities. Deep tendon reflexes are all 2+ throughout the bilateral upper extremities. Arterial pulses are all 2+ and symmetrical with normal amplitude throughout the bilateral upper extremities. The utilization review did not grant the request on 03/25/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the right elbow: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS ODG-TWC, Treatment, Integrated Treatment/Disability Duration Guidelines, Elbow (Acute & Chronic) (updated 02/14/14): MRI's - Indications for imaging - Magnetic resonance imaging.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Official Disability Guidelines, Treatment Workers Compensation Guidelines, Elbow MRI.

Decision rationale: This patient presents with right shoulder and right elbow pain. The provider is requesting an MRI of the right elbow. The MTUS and ACOEM Guidelines do not address this request; however, Official Disability Guidelines on MRI for the elbow state that it is recommended as it may provide important diagnostic information for evaluating the elbow in many different conditions including: Collateral ligament injury, epicondylitis, injury to the biceps and triceps tendons, abnormality of the ulnar, radial, or median nerve, and from masses about the elbow joint. The review of 88 pages of records does not show a previous MRI of the right elbow. In this case, the patient is already status post epicondylectomy and the provider does not explain what he is concerned about for which an MRI is requested. Therefore, the request is not medically necessary.

Extracorporeal shockwave therapy (frequency unspecified), quantity: 3: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS ODG-TWC, Treatment, Integrated Treatment/Disability Duration Guidelines, Elbow (Acute & Chronic) (updated 02/14/14): Extracorporeal shockwave therapy (ESWT) and Non-MTUS ACOEM California Guidelines Plus - Extracorporeal Shockwave Therapy.

MAXIMUS guideline: Decision based on MTUS ACOEM Practice Guidelines, Chapter 10 Elbow Disorders, page 235 and on the Non-MTUS Official Disability Guidelines, ESWT for elbow problems.

Decision rationale: This patient presents with right shoulder and right elbow pain. The provider is requesting extracorporeal shockwave therapy x 3. The ACOEM Guidelines page 235 on ESWT for the elbow states, Publish randomized clinical trials are needed to provide better evidence for the use of many physical modalities that are commonly employed. Some therapists use a variety of procedures; conclusions regarding their effectiveness may be based on anecdotal reports or case studies. The Official Disability Guidelines further states that ESWT for the elbow is not recommended when using high energy ESWT but under study for the low energy ESWT where the latest studies show better outcomes without the need for anesthesia. The Official Disability Guidelines goes onto state, ESWT cannot be recommended at this time for epicondylitis, although it has very few side effects. Given the lack of support from Official Disability Guidelines Therefore, the request, is not medically necessary.

Additional physical therapy (frequency unspecified), right upper extremity, Quantity: 8:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation ODG-TWC, ODG Treatment, Integrated Treatment/Disability Duration Guidelines, Elbow (Acute & Chronic) (updated 02/14/14): ODG Physical Therapy Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment Guidelines, Physical Medicine page 98, 99.

Decision rationale: This patient presents with right shoulder and right elbow pain. The provider is requesting additional physical therapy for the right upper extremity, quantity 8. The MTUS Guidelines page 98 and 99 on physical medicine recommends 8 to 10 visits for myalgia, myositis, and neuralgia symptoms. The review of 88 pages of records do not show any recent or prior physical therapy reports to verify how many treatments were received and with what results were accomplished. The UR referenced a physical therapy report dated 07/11/2013 showing that the patient reportedly had 70% overall improvement; however, the patient has been having difficulty with reaching and overhead activities with continued right shoulder pain and difficulty with range of motion. The UR also noted that the patient completed 20 postoperative physical therapy sessions. The UR further documents on 03/18/2014 that [REDACTED] requested authorization for 8 additional sessions of physical therapy with emphasis on shoulder and elbow strengthening exercises. In this case, it appears that the patient had some 20 physical therapy sessions. While the patient continues to report difficulty with shoulder mobility and ROM, she should be able to start a self-directed home exercise program to strengthen the shoulder and elbow. Therefore, the request is not medically necessary.

TENS unit supplies, per month, quantity unspecified: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of TENS Page(s): 116-117.

MAXIMUS guideline: Decision based on MMTUS Chronic Pain Medical Treatment Guidelines, TENS, chronic pain (transcutaneous electrical nerve stimulation) page 114-116.

Decision rationale: This patient presents with right shoulder and right elbow pain. The provider is requesting a TENS unit supply per month, quantity unspecified. The MTUS Guidelines page 114 to 116 on TENS unit supports its use for neuropathic pain conditions which this patient may be suffering from. However, for a home unit use, documentation of use and functional improvement is required. In this case, despite the review of records from 01/06/2014 to 05/08/2014, there is no documentation of the patient's use of the unit. More importantly, there is no documentation that the TENS unit is reducing the patient's pain and improving function. Therefore, the request is not medically necessary.