

Case Number:	CM14-0063560		
Date Assigned:	07/11/2014	Date of Injury:	02/27/2013
Decision Date:	09/30/2014	UR Denial Date:	04/18/2014
Priority:	Standard	Application Received:	05/06/2014

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 Medicine 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:

This is a 39-year-old female who reported an industrial injury on 2/27/2013, over 18 months ago, attributed to the performance of her usual and customary job duties. The patient was reported to complain of right shoulder, right wrist pain along with migraine headaches. The objective findings on examination included pain with range of motion of the neck, pain with range of motion the right shoulder, right elbow range of motion pain and right wrist hand pain with range of motion; tenderness to palpation to the same areas; reported sensory loss in the right hand; trigger points are documented for the cervical spine; positive orthopedic testing and MRA imaging. The diagnoses included rotator cuff syndrome, right side mile fasciitis, rule out right carpal tunnel syndrome, anxiety, stress, headaches, insomnia, cervical disc syndrome, cervical spine radiculitis; pain in the cervical spine, pain in the right shoulder, pain in the right elbow, pain in the wrist, right shoulder internal derangement, right elbow internal derangement, and partial right rotator cuff tear per MRI. The treatment plan included physical therapy; shock wave therapy; pain management; DME; orthopedic surgeon consultation; a home exercise kit; a cervical spine traction unit; braces and support; cervical spine posture pump; right wrist brace; and paraffin baths. The patient placed on TDD status the patient was ordered a hinged elbow brace along with ESWT to the elbow.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right elbow hinged brace: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Treatment Integrated/ Disability Duration Guidelines Elbow (Acute and Chronic) page 26 of 199.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 235. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) elbow chapter-exercise; splinting; physical therapy.

Decision rationale: The request for authorization of a hinged elbow brace for the treatment of the reported elbow symptoms while active is not supported with objective evidence to support the medical necessity of the requested brace. The criterion recommended by the CA MTUS, the Official Disability Guidelines, and the Medical Treatment Utilization Schedule has not been documented. The provider has cited no objective findings other than tenderness to the elbow and has provided no nexus to the cited mechanism of injury. The hinged elbow brace is not demonstrated to be medically necessary for the effects of the industrial injury. There is no rationale supported by objective evidence by the requesting physician to support the medical necessity of the prescription of a hinged elbow brace.

Shock wave therapy: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Treatment Integrated Treatment/ Disability Duration Guidelines, Elbow (Acute and Chronic) page 16 of 199; Ankle and Foot chapter; Shoulder chapter; Criteria for the use of extracorporeal shock wave therapy.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 10 Elbow Disorders (Revised 2007) Page(s): 29, 203, 235. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder---ESWT.

Decision rationale: The request for ESWT to the right elbow does not provide any objective evidence to support the medical necessity of the requested ESWT. The patient is being treated for carpal tunnel syndrome with a reported lateral epicondylitis. There is no demonstrated evidence of a calcific tendinitis. The requested treatment is not demonstrated to be medically necessary and is not consistent with the recommendations of the CA MTUS. There is no rationale provided to support the medical necessity of the performed ESWT directed to the right elbow. The treatment of the wrists with ESWT is not recommended by the CA MTUS, the ACOEM Guidelines, or the Official Disability Guidelines unless certain criteria are met with specific diagnoses. The provider did not provide any objective evidence to support the use of ESWT for the diagnosed right elbow epicondylitis pain that was demonstrated on the physical examination as only tenderness to palpation. There is no provided objective evidence that the use of ESWT for the symptoms related to the objective findings documented for this patient is medically necessary or leads to functional improvement. There is no demonstrated medical necessity for ESWT to the right elbow for this patient. The CA MTUS is silent on the use of ESWT. The Official Disability Guidelines only recommend the use of ESWT to the shoulder, elbow, and knee under certain clinical situations directed to the treatment of a calcific tendonitis

or a prepatellar bursitis. It is not clear that the requesting provider has demonstrated a failure of conservative care and the decision to proceed with the requested treatment against the recommendations of the currently accepted guidelines is not demonstrated to be medically necessary. The use of conservative treatment must be performed for at least 6 months with documentation of treatment failure. There is no demonstrated medical necessity for the ESWT directed to the right elbow.