

Case Number:	CM14-0203818		
Date Assigned:	12/16/2014	Date of Injury:	11/14/2012
Decision Date:	02/03/2015	UR Denial Date:	10/29/2014
Priority:	Standard	Application Received:	12/05/2014

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 Emergency Medicine, has a subspecialty in ENTER SUBSPECIALTY 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 injured worker is a 50 year-old female, who sustained an injury on November 14, 2012. The mechanism of injury is not noted. Treatments have included: physical therapy, medications. The current diagnoses are: right wrist strain/sprain , cervical strain/sprain with radiculitis, thoracolumbar strain, right shoulder sprain, right elbow epicondylitis. The stated purpose of the request for ESWT to right wrist 1 x 4 was not noted. The request for ESWT to right wrist 1 x 4 was denied on October 29, 2014 citing a lack of documentation of guideline support. The stated purpose of the request for Amitriptyline 10%, Dextromethorphan 10%, Gabapentin 10% in cream base, 210 gm was not noted. The request for Amitriptyline 10%, Dextromethorphan 10%, Gabapentin 10% in cream base, 210 gm was denied on October 29, 2014, citing a lack of documentation of guideline support. The stated purpose of the request for Flurbiprofen 20%, Tramadol 20% in cream base, 210 gm was not noted. The request for Flurbiprofen 20%, Tramadol 20% in cream base, 210 gm was denied on October 29, 2014, citing a lack of documentation of guideline support. The stated purpose of the request for Physical therapy 2 x 6 was not noted. The request for Physical therapy 2 x 6 was denied on October 29, 2014, citing a lack of documentation of functional improvement. Per the report dated September 29, 2014, the treating physician noted complaints of pain to the neck, back, right shoulder, right elbow/forearm and right hand/wrist with numbness. Exam showed tenderness and spasm to the cervical/thoracic/lumbar spines, right upper extremity, positive right shoulder impingement sign.

IMR ISSUES, DECISIONS AND RATIONALES

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

ESWT to right wrist 1 x 4: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation ODG -TWC ODG Treatment Integrated Treatment/Disability Duration Guidelines Forearm, Wrist, & Hand (Acute & Chronic) (Not including "Carpal Tunnel Syndrome") Go to chapter on Carpal Tunnel Syndrome or Back to ODG - TWC Index (updated 11/13/14).

Decision rationale: The requested ESWT to right wrist 1 x 4 is not medically necessary. American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 9, Shoulder Complaints, Initial Care, Page 203, note "Some medium quality evidence supports manual physical therapy, ultrasound and high-energy extracorporeal shock wave therapy for calcifying tendonitis of the shoulder. At least three conservative treatments have been performed prior to use of ESWT. These would include: (a) Rest; (b) Ice; (c) NSAIDs; (d) Orthotics; (e) Physical Therapy; (e) Injections (Cortisone). Maximum of 3 therapy sessions over 3 weeks;" and ODG noted no recommendations for this treatment for the wrist. The injured worker has pain to the neck, back, right shoulder, right elbow/forearm and right hand/wrist with numbness. The treating physician has documented at least 24 completed physical therapy sessions, and noted tenderness and spasm to the cervical/thoracic/lumbar spines, right upper extremity, and positive right shoulder impingement sign. The treating physician has not documented diagnostic or exam evidence of calcific tendonitis nor noted this as a diagnostic impression, nor results of cortisone injections. The criteria noted above have not been met. Therefore, the request for ESWT to right wrist 1 x 4 is not medically necessary.

Amitriptyline 10%, Dextromethorphan 10%, Gabapentin 10% in cream base, 210 gm: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The requested Amitriptyline 10%, Dextromethorphan 10%, Gabapentin 10% in cream base, 210 gm, is not medically necessary. California Medical Treatment Utilization Schedule (MTUS), 2009, Chronic pain, pages 111-113, Topical Analgesics, do not recommend topical analgesic creams as they are considered "highly experimental without proven efficacy and only recommended for the treatment of neuropathic pain after failed first-line therapy of antidepressants and anticonvulsants". The injured worker has pain to the neck, back, right shoulder, right elbow/forearm and right hand/wrist with numbness. The treating physician has documented at least 24 completed physical therapy sessions, and noted tenderness and spasm

to the cervical/thoracic/lumbar spines, right upper extremity, and positive right shoulder impingement sign. The treating physician has not documented trials of anti-depressants or anticonvulsants. The treating physician has not documented intolerance to similar medications taken on an oral basis. The criteria noted above not having been met, Amitriptyline 10%, Dextromethorphan 10%, Gabapentin 10% in cream base, 210 gm is not medically necessary.

Flurbiprofen 20%, Tramadol 20% in cream base, 210 gm: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The requested Flurbiprofen 20%, Tramadol 20% in cream base, 210 gm, is not medically necessary. California Medical Treatment Utilization Schedule (MTUS), 2009, Chronic pain, page 111-113, Topical Analgesics, do not recommend topical analgesic creams as they are considered "highly experimental without proven efficacy and only recommended for the treatment of neuropathic pain after failed first-line therapy of antidepressants and anticonvulsants". The injured worker has pain to the neck, back, right shoulder, right elbow/forearm and right hand/wrist with numbness. The treating physician has documented at least 24 completed physical therapy sessions, and noted tenderness and spasm to the cervical/thoracic/lumbar spines, right upper extremity, and positive right shoulder impingement sign. The treating physician has not documented trials of anti-depressants or anticonvulsants. The treating physician has not documented intolerance to similar medications taken on an oral basis. The criteria noted above have not been met. Therefore, Flurbiprofen 20%, Tramadol 20% in cream base, 210 gm: is not medically necessary.

Physical Therapy 2 x 6: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back, Acute and Chronic, Physical therapy.

Decision rationale: The requested Physical therapy 2 x 6 is not medically necessary. American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), CHAPTER 8, Neck and Upper Back Complaints, Summary of Recommendations and Evidence, Page 181; and Official Disability Guidelines (ODG), Neck and Upper Back, Acute and Chronic, Physical therapy, recommend continued physical therapy with documented objective evidence of derived functional benefit. The injured worker has pain to the neck, back, right shoulder, right elbow/forearm and right hand/wrist with numbness. The treating physician has documented at least 24 completed physical therapy sessions, and noted tenderness and spasm to the cervical/thoracic/lumbar spines, right upper extremity, and positive right shoulder impingement

sign. The treating physician has not documented sufficient objective evidence of derived functional benefit from completed physical therapy sessions, or the medical necessity for additional physical therapy to accomplish a transition to a dynamic home exercise program. The criteria noted above have not been met. Therefore, Physical therapy 2 x 6 is not medically necessary.