

Case Number:	CM14-0206205		
Date Assigned:	12/18/2014	Date of Injury:	12/27/2013
Decision Date:	02/23/2015	UR Denial Date:	12/02/2014
Priority:	Standard	Application Received:	12/09/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabn, Pain Management

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 patient with a date of injury of 12/27/13. A utilization review determination dated 12/2/14 recommends non-certification/modification of Mobic, Fluriflex/TG Hot, IF unit, x-rays, PT, EMG/NCV BUE, ECSWT, and FCE. No current medical reports from the requesting provider are included for review. 10/24/14 medical report from a different provider identifies left wrist pain 5/10 with tenderness. A left wrist injection was performed.

IMR ISSUES, DECISIONS AND RATIONALES

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

Mobic 7.5mg: 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) Treatment Index 9th Edition (web) 2011

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-72 of 127.

Decision rationale: Regarding the request for Mobic, Chronic Pain Medical Treatment Guidelines state that NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Within the documentation available for review, there is no indication that NSAIDs are providing any specific analgesic benefits (in terms of percent pain reduction or reduction in numeric rating scale) or any objective functional improvement. In the absence of such documentation, the currently requested Mobic is not medically necessary.

Fluriflex/TG Hot 180gm: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113 of 127.

Decision rationale: Regarding the request for Fluriflex and TG Hot, CA MTUS states that topical compound medications require guideline support for all components of the compound in order for the compound to be approved. Topical NSAIDs are indicated for "Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic pain: Not recommended as there is no evidence to support use." Capsaicin is "Recommended only as an option in patients who have not responded or are intolerant to other treatments." Muscle relaxants and antiepilepsy drugs are not supported by the CA MTUS for topical use. Within the documentation available for review, none of the abovementioned criteria have been documented. Furthermore, there is no clear rationale for the use of topical medications rather than the FDA-approved oral forms for this patient. Given all of the above, the requested Fluriflex/TG Hot 180gm are not medically necessary.

Interferential Unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-120 of 127.

Decision rationale: Regarding the request for interferential unit, CA MTUS Chronic Pain Medical Treatment Guidelines state that interferential current stimulation is not recommended as an isolated intervention. They go on to state that patient selection criteria if interferential stimulation is to be used anyways include pain is ineffectively controlled due to diminished effectiveness of medication, side effects or history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercises, or unresponsive to conservative treatment (repositioning, ice/heat, etc.). If those criteria are met, then in one month trial may be appropriate to study the effects and benefits. With identification of objective functional improvement, additional interferential unit use may be supported. Within the documentation

available for review, there is no indication that the patient has met the selection criteria for interferential stimulation as outlined above. Additionally, there is no documentation that the patient has undergone an interferential unit trial with objective functional improvement and there is no provision for modification of the current request. In light of the above issues, the currently requested interferential unit is not medically necessary.

Physical therapy to the left shoulder, elbow and wrist 2 times a week for 6 weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99 of 127.

Decision rationale: Regarding the request for physical therapy, Chronic Pain Medical Treatment Guidelines recommend up to 10 sessions with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. Within the documentation available for review, there is no documentation of specific objective functional improvement with any previous PT sessions and remaining deficits that cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. Furthermore, the request exceeds the amount of PT recommended by the CA MTUS and, unfortunately, there is no provision for modification of the current request. In light of the above issues, the currently requested physical therapy is not medically necessary.

EMG/Nerve Conduction Study Bilateral Upper Extremities: 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) Treatment Index 9th Edition (web) 2011

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178, 182.

Decision rationale: Regarding the request for EMG/NCS of bilateral upper extremities, CA MTUS and ACOEM state that the electromyography and nerve conduction velocities including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. Guidelines go on to state that EMG is recommended to clarify nerve root dysfunction if findings of history and physical exam are consistent. Within the documentation available for review, there are no recent subjective complaints or physical examination findings identifying subtle focal neurologic deficits suggestive of radiculopathy and/or peripheral neuropathy. In the absence of such documentation, the currently requested EMG/NCS of bilateral upper extremities is not medically necessary.

ECSWT (extracorporeal shockwave therapy) to the wrist: 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) Treatment Index 9th Edition (web) 2014

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Anthem Medical Policy # SURG.00045 Extracorporeal Shock Wave Therapy for Orthopedic Conditions.

Decision rationale: Regarding the request for ECSWT (Extracorporeal shock wave therapy) for the wrist, California MTUS does not address the issue. ODG does not address the issue for the wrists. Anthem medical policy notes that ESWT for the treatment of musculoskeletal conditions is considered investigational and not medically necessary. In light of the above issues, the currently requested ECSWT (Extracorporeal shock wave therapy) for the wrist is not medically necessary.

Functional Capacity Evaluation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 1 Prevention Page(s): 12. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Fitness for Duty Chapter, Functional Capacity Evaluation.

Decision rationale: Regarding request for functional capacity evaluation, Occupational Medicine Practice Guidelines state that there is not good evidence that functional capacity evaluations are correlated with a lower frequency of health complaints or injuries. ODG states that functional capacity evaluations are recommended prior to admission to a work hardening program. The criteria for the use of a functional capacity evaluation includes case management being hampered by complex issues such as prior unsuccessful return to work attempts, conflicting medical reporting on precautions and/or fitness for modified job, or injuries that require detailed explanation of a worker's abilities. Additionally, guidelines recommend that the patient be close to or at maximum medical improvement with all key medical reports secured and additional/secondary conditions clarified. Within the documentation available for review, there is no indication that the patient is close to or at MMI with case management being hampered by complex issues as outlined above. In the absence of clarity regarding those issues, the currently requested functional capacity evaluation is not medically necessary.

X-rays of cervical spine and left wrist: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 258.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 8 Neck and Upper Back Complaints Page(s): 177-178, 268, 272.

Decision rationale: Regarding request for x-rays, CA MTUS and ACOEM state that cervical spine x-rays should not be recommended in patients with neck pain in the absence of red flags

for serious spinal pathology even if the pain has persisted for at least 6 weeks. California MTUS supports wrist x-rays for red flag conditions such as fracture, dislocation, and osteoarthritis or after a 4-6 weeks period of conservative treatment when specific conditions such as a scaphoid fracture are suspected. They recommend against routine use for evaluation of forearm, wrist, and hand conditions. Within the documentation available for review, there is no current documentation from the requesting provider identifying any specific symptoms/findings and a rationale for the use of cervical spine and left wrist x-rays. In the absence of clarity regarding those issues, the currently requested x-rays are not medically necessary.