

Case Number:	CM15-0004869		
Date Assigned:	01/16/2015	Date of Injury:	08/11/2014
Decision Date:	03/30/2015	UR Denial Date:	12/19/2014
Priority:	Standard	Application Received:	01/09/2015

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: New York
 Certification(s)/Specialty: Internal Medicine

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 61 year old female, who sustained an industrial injury on August 11, 2014. She has reported bilateral wrists and right shoulder/upper arm strain from repetitive motion injury. The diagnoses have included rule out overuse syndrome of right extremity (active), rule out overuse syndrome of left extremity (active), right shoulder/upper arm strain and right internal derangement of shoulder. Treatment to date has included diagnostic studies, physical therapy, acupuncture and medication. Currently, the injured worker complains of left wrist, right wrist and right shoulder pain and strain. Her right shoulder pain is not improved with rest at home. Right shoulder symptoms also included some numbness in her hands. This was mainly precipitated by folding her wrists or sleeping on the arm. On December 19, 2014, Utilization Review non-certified extracorporeal shock wave therapy to the right shoulder, physical performance Functional Capacity Evaluation, interferential unit, hot/cold unit, Fluriflex 180 grams and TGHot 180 grams, noting the Medical Treatment Utilization Schedule and Official Disability Guidelines. On January 9, 2015, the injured worker submitted an application for Independent Medical Review for review of extracorporeal shock wave therapy to the right shoulder, physical performance Functional Capacity Evaluation, interferential unit, hot/cold unit, Fluriflex 180 grams and TGHot 180 grams.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy evaluation and treatment bilateral shoulder, elbows and wrists qty:12:
Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder (Acute & Chronic)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98 ? 99. Decision based on Non-MTUS Citation Physical Therapy Chapter

Decision rationale: MTUS and ODG guidelines recommend 10 physical therapy visits over 8 weeks for medical management of shoulder impingement syndrome, and 9 visits over 8 weeks for sprains and strains of wrist or hand. As time goes, one should see an increase in the active regimen of care or decrease in the passive regimen of care, with a fading of treatment of frequency. When the treatment duration and/or number of visits exceeds the guidelines, exceptional factors should be noted. At the time that additional physical therapy was prescribed, the injured worker had completed 6 visits with no evidence of significant functional improvement. With the number of visits below recommended guidelines, the request for Physical Therapy evaluation and treatment bilateral shoulders, elbows and wrists, quantity 12, is medically necessary

ECSWT right shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder (Acute & Chronic), Extracorporeal Shock Wave Therapy

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Not addressed. Decision based on Non-MTUS Citation Shoulder Chapter, Extracorporeal shock wave therapy (ESWT)

Decision rationale: Per guidelines, Extracorporeal Shockwave Treatment (ESWT) is approved for the treatment of Rotator cuff tendonitis associated with calcific deposits in the tendon (calcific tendonitis). It is recommended for use in patients whose pain has remained despite six months of standard treatment and at least three conservative treatment modalities, including rest, Ice, NSAIDs, Orthotics, Physical Therapy and Cortisone injections. The injured worker complaints of right shoulder pain secondary to internal derangement of the shoulder. Documentation fails to show that the injured worker has failed 6 months of standard therapy or conservative treatment that would fit criteria for prescribing ESWT. The request for extracorporeal shock wave therapy to the right shoulder is not medically necessary.

Physical performance functional capacity evaluation: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional Improvement Measures Page(s): 48.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain programs, Functional restoration programs (FRPs) Page(s): 49. Decision based on Non-MTUS Citation Chronic Pain Programs

Decision rationale: Per guidelines, Functional Restorative Programs were designed to use a medically directed, interdisciplinary pain management approach geared specifically to patients with chronic disabling occupational musculoskeletal disorders. They are recommended for patients with conditions that have resulted in delayed recovery. Chart documentation indicates that the injured worker is undergoing active treatment for bilateral wrist and shoulder pain. Not having reached maximum medical therapy at the time of the request under review, guidelines have not been met. The request for physical performance Functional Capacity Evaluation is not appropriate or medically necessary.

Interferential unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118-120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy, Interferential Current Stimulation (ICS) Page(s): 118.

Decision rationale: MTUS states that Electrotherapy is not recommended as an isolated intervention. It may be appropriate for patients with significant pain from postoperative conditions that limit the ability to perform exercise programs/physical therapy treatment, or if unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). Chart documentation indicates that the injured worker is undergoing standard conservative treatment for bilateral wrist and shoulder pain, with no prior surgical intervention for this condition. The request for interferential unit, hot/cold unit is not medically necessary by MTUS.

Hot/cold unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines, 9th Edition, Knee Chapter, Continuous Flow Cryotherapy

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Not addressed. Decision based on Non-MTUS Citation Cold and Heat Packs

Decision rationale: Per guidelines, Cold and Heat Packs are recommended as an option for treatment of acute pain, particularly low back pain. The injured worker complaints of persistent bilateral wrist and shoulder pain, currently being treated with other treatment modalities including medications and physical therapy. The request for Hot/Cold unit is not medically necessary.

Fluriflex 180gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic), Topical Analgesics

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

Decision rationale: MTUS states that use of topical analgesics is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many of these agents. Fluriflex is a topical analgesic containing Flurbiprofen (an anti-inflammatory) and Cyclobenzaprine (a muscle relaxant). MTUS states that the use of muscle relaxants as a topical agent is not recommended. Per guidelines, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The request for Fluriflex 180 grams is not medically necessary.

TGHot 180gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines, Topical Analgesics

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

Decision rationale: MTUS states that use of topical analgesics is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many of these agents. TGHot is a topical analgesic containing Tramadol, Gabapentin, Menthol, Camphor and Capsaicin. MTUS states that the use of topical Gabapentin is not recommended. Per guidelines, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The request for TGHot 180 grams is not medically necessary.