

Case Number:	CM15-0138400		
Date Assigned:	07/28/2015	Date of Injury:	04/11/2014
Decision Date:	08/25/2015	UR Denial Date:	06/11/2015
Priority:	Standard	Application Received:	07/16/2015

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: North Carolina

Certification(s)/Specialty: Family Practice

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 47 year old female who sustained an industrial injury on April 11, 2014. She reports she hit the floor with the metal rod while changing a squeegee. She reports a popping sensation in the right shoulder followed by pain in the right arm. She has reported a right shoulder and right arm injury and has been diagnosed with craniocervical headaches versus headaches due to exposure to chemicals, cervical spine sprain strain with right shoulder weakness, no degenerative changes of subluxation, right shoulder sprain strain with impingement, right elbow asymptomatic ulnar canal syndrome, and right wrist sprain strain with carpal tunnel syndrome and De Quervain's. Treatment has included medical imaging, physical therapy, manipulation therapy, acupuncture, injections, and medications. There was tenderness to palpation of the cervical spine with decreased range of motion. There was tenderness to palpation of the shoulders. Impingement sign was positive on the right with decreased range of motion to both the right and left shoulder. There was pain to palpation of the right medial epicondyle and right wrist. The treatment plan included physical therapy, medications, and acupuncture. The treatment request included cyclo/Tramadol, 1 solar care FIR heating system with FIR heating pad, and 3 extracorporeal shockwave therapy sessions.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cyclo/Tramadol with 1 refill: Upheld

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

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

Decision rationale: The California chronic pain medical treatment guidelines section on topical analgesics states: Recommended as an option as indicated below. Largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. (Namaka, 2004) These agents are applied locally to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. (Colombo, 2006) Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor). (Argoff, 2006) There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The requested medication contains ingredients (Cyclobenzaprine and Tramadol), which are not indicated per the California MTUS for topical analgesic use. Therefore, the request is not medically necessary.

Solar care FIR heating system with FIR heat pad: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

Decision rationale: The ACOEM chapter on wrist complaints does recommended local application of cold in the acute phase of injury and thereafter the alternate application of cold or heat. There is not a specific recommendation for infrared heat and there is not an explained reason why the patient could not simply use home heat compresses. Therefore, the request is not medically necessary.

3 extracorporeal shockwave therapy (ESWT) sessions: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shockwave therapy.

Decision rationale: The California MTUS and the ACOEM do not specifically address the requested service. Per the Official Disability Guidelines section on shockwave therapy: Not recommended, particularly using high energy ESWT. It is under study for low energy ESWT. The value, if any, for ESWT treatment of the elbow cannot be confirmed or excluded. Criteria for use of ESWT include: 1. Pain in the lateral elbow despite six months of therapy. 2. Three conservative therapies prior to ESWT have been tried prior. 3. No contraindications to therapy. 4. Maximum of 3 therapy sessions over 3 weeks. The ACOEM low back chapter does not recommend this as a treatment modality in the wrist complaints chapter. The request does not meet ODG guidelines. Therefore, the request is not medically necessary.