

Case Number:	CM15-0141139		
Date Assigned:	07/30/2015	Date of Injury:	12/30/2008
Decision Date:	09/23/2015	UR Denial Date:	06/29/2015
Priority:	Standard	Application Received:	07/20/2015

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: Texas, New York, California
 Certification(s)/Specialty: Preventive Medicine, Occupational 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 applicant is a represented [REDACTED] beneficiary who has filed a claim for chronic shoulder and wrist pain reportedly associated with an industrial injury of December 30, 2008. In multiple Utilization Review reports dated June 29, 2015, the claims administrator failed to approve requests for a functional capacity evaluation, bio-gloves, topical compounded agent, extracorporeal shockwave therapy for the wrist, and a sleep study. The claims administrator referenced a progress note of June 17, 2015 and May 22, 2015 in its determination. The applicant's attorney subsequently appealed. On May 22, 2015, the applicant reported ongoing complaints of bilateral wrist and bilateral shoulder pain. The applicant's psychiatric review of systems was positive for depression and anxiety. Numbness and tingling about the wrist were also reported. The applicant exhibited positive Phalen's, Tinel, and Finkelstein's signs about the bilateral wrists. The applicant was given diagnosis of bilateral shoulder tendonitis and bilateral carpal tunnel syndrome. Extracorporeal shockwave therapy, physical therapy, MRI imaging of the shoulder, and MRI of the bilateral wrists were endorsed, along with a sleep study and a functional capacity evaluation. EKG testing gloves/splints for the wrists, and several topical compounded medications were prescribed and/or continued while the applicant was placed off of work, on total temporary disability.

IMR ISSUES, DECISIONS AND RATIONALES

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

Functional capacity evaluation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 75-92.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation Page(s): 21, Chronic Pain Treatment Guidelines Work conditioning, work hardening Page(s): 125.

Decision rationale: No, the request for a functional capacity evaluation was not medically necessary, medically appropriate, or indicated here. While MTUS Guideline in ACOEM Chapter 2, page 21 does suggest considering a functional capacity evaluation when necessary to translate medical impairment into limitations and restrictions and to determine work capability. Here, however, the applicant was off of work, on total temporary disability, it was reported on May 22, 2015. The applicant had failed to return to work some six and a half years removed from the date of injury. It did not appear that the applicant had a job to return to. It was not clearly stated, in short, why functional capacity testing was sought in the clinical and/or vocational context present here. While page 125 of the MTUS Chronic Pain Medical Treatment Guidelines does support usage of functional capacity evaluation as a precursor to enrollment in a work hardening program, here, however, there was no mention of the applicant's willingness to consider or contemplate any kind of work hardening program on or around date in question, May 22, 2015. Therefore, the request was not medically necessary.

Bio gloves: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 264-266.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 272.

Decision rationale: Conversely, the request for bio-gloves was medically necessary, medically appropriate, or indicated here. One of the operating diagnoses as of the date in question, May 22, 2015 was carpal tunnel syndrome, the treating provider reported on that date. The applicant reported issues with numbness, tingling, and paresthesias about the bilateral wrists, it was stated on that date. Positive Tinel's and Phalen's signs were also reported about the wrists on the date. The MTUS Guideline in ACOEM Chapter 11, Table 11-7, page 272 does recommend splinting as a first-time conservative treatment for carpal tunnel syndrome, as was present here. The bio-gloves at issue did seemingly represent a form of splinting for carpal tunnel syndrome. Therefore, the request was medically necessary.

Gabacyclotram- 180n grams (Gabapentin 10%/ Cyclobenzaprine 6%/Tramadol 10%):
Upheld

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

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

Decision rationale: The request for a Gabacyclotram topical compound was not medically necessary, medically appropriate, or indicated here. As noted on page 113 of the MTUS Chronic Pain Medical Treatment Guidelines, gabapentin, the primary ingredient in the compound, is not recommended for topical compound formulation purposes. Since one or more ingredients in the compound is not recommended, the entire compound is not recommended, per page 111 of the MTUS Chronic Pain Medical Treatment Guidelines. Therefore, the request is not medically necessary.

Sleep study: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain, Polysomnography.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress, Polysomnography (PSG) and Other Medical Treatment Guidelines.

Decision rationale: Similarly, the request for a sleep study was not medically necessary, medically appropriate, or indicated here. The MTUS does not address the topic. However, the American Academy of Sleep Medicine (AASM) notes that Polysomnography is not indicated in the routine evaluation of insomnia, including insomnia due to psychiatric or neuro psychiatric disorders. Here, the applicant's psychiatric review of systems, per the May 22, 2015 progress note in question, was positive for anxiety and depression. A sleep study would have been of no benefit in establishing the presence or absence of depression-induced insomnia, per AASM. ODG's Mental Illness and Stress Chapter Polysomnography topic, which is also based, in large part, on the AASM position, also advises against sleep studies in individuals with chronic insomnia, unless symptoms suggest a comorbid sleep disorder. Here, all evidence on file point to the applicant is carrying a diagnosis of chronic pain-induced insomnia and/or mental health- induced insomnia, i.e. conditions for which a sleep study would be of no benefit in establishing or diagnosing. Therefore, the request is not medically necessary.

Extracorporeal shock wave therapy (ESWT) for the bilateral wrists: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, 13th Edition, Shoulder, Extracorporeal Shock Wave Therapy (ESWT).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 29, Chronic Pain Treatment Guidelines Ultrasound, therapeutic Page(s): 123. Decision based on Non-MTUS Citation ACOEM Occupational Medicine Practice Guidelines, 3rd ed., Knee Disorders, pg. 940. For most body parts, there is evidence that ESWT is ineffective (see Elbow Disorders, Shoulder Disorders, and Ankle and Foot Disorders chapters).

Decision rationale: The request for extracorporeal shockwave therapy for the bilateral wrists was not medically necessary, medically appropriate, or indicated here. Extracorporeal shockwave therapy is a subset of therapeutic ultrasound, which, per page 123 of the MTUS Chronic Pain Medical Treatment Guidelines is "not recommended" in the chronic pain context present here. The MTUS Guideline for a proximate body part, the elbow, in ACOEM Chapter 10, page 29 also notes that extracorporeal shockwave therapy is "strongly recommended against" for elbow epicondylitis, i.e., condition essentially analogous to the applicant's wrist tendonitis/wrist tenosynovitis. The Third Edition ACOEM Guidelines Knee Chapter likewise notes that, for most body parts, that there is evidence that extracorporeal shockwave therapy is "ineffective." The attending provider's May 22, 2015 progress note failed to furnish a clear or compelling rationale for selection of this particular modality in the face of the seemingly unfavorable MTUS and ACOEM positions on the same. Therefore, the request was not medically necessary.