

Case Number:	CM15-0026956		
Date Assigned:	02/19/2015	Date of Injury:	08/16/2013
Decision Date:	05/20/2015	UR Denial Date:	01/26/2015
Priority:	Standard	Application Received:	02/12/2015

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 32 year old female, who sustained an industrial injury on August 16, 2013. The mechanism of injury was not specifically stated. The injured worker has reported neck, right shoulder and right arm pain. The diagnoses have included right medical epicondylitis, cervicgia, right arm radiculopathy, right carpal tunnel syndrome, right shoulder impingement syndrome and right shoulder pain. Treatment to date has included pain management, transcutaneous electrical nerve stimulation, physical therapy, right shoulder corticosteroid injection, electromyography and a home exercise program. The documentation notes that the injured worker had good benefit from a prior steroid injection and physical therapy. Current documentation dated January 15, 2015 notes that he injured worker complained of increased neck and right shoulder pain. Physical examination of the cervical spine revealed tenderness to palpation of the right paracervical muscles and right trapezius muscles into the right medical scapular border. Range of motion was decreased. Grip strength was a 4/5. Right shoulder examination revealed a decreased range of motion and a positive impingement test. Treatment recommendations included a steroid injection, physical therapy, TENS pads, and continuation of the current medication regimen. A Request for Authorization Form was then submitted on 01/23/2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 steroid injection with Kenalog, Marcaine, and Lidocaine under ultrasound guidance to right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205.

Decision rationale: California MTUS/ACOEM Practice Guidelines state invasive techniques have a limited proven value. If pain with elevation significantly limits activities, a subacromial injection of a local anesthetic and a corticosteroid may be indicated after conservative therapy for 2 to 3 weeks. In this case, it is noted that the injured worker has been previously treated with a right shoulder steroid injection. According to the documentation provided, the injured worker underwent a right shoulder steroid injection in 02/2014 with significant improvement. While it is noted that the injured worker has failed to respond to conservative therapy including physical therapy and NSAID medication, the medical necessity for a steroid injection using Kenalog, Marcaine and lidocaine under ultrasound guidance has not been established. The injured worker was issued a previous authorization for 1 steroid injection with Kenalog, Marcaine and lidocaine without the use of ultrasound guidance in 01/2015. The medical necessity for the use of ultrasound guidance has not been established in this case. Therefore, the request is not medically necessary.

Unknown physical therapy visits: Upheld

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

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

Decision rationale: California MTUS Guidelines state active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. There is no documentation of significant functional improvement following the initial course of physical therapy. The provider noted a failure of conservative treatment to include physical therapy. The request as submitted failed to indicate the specific quantity and sessions and the specific body part to be treated. Given the above, the request is not medically necessary.

Unknown prescription of Tramadol: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74-82.

Decision rationale: California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects should occur. The request as submitted failed to indicate the strength, frequency or quantity of the medication. Given the above, the request is not medically necessary.

Flector patches #30: 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.

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

Decision rationale: California MTUS Guidelines state the only FDA approved topical NSAID is diclofenac, which is indicated for the relief of osteoarthritis pain. The injured worker does not maintain a diagnosis of osteoarthritis. In addition, there was no evidence of a failure of first line oral medication prior to the initiation of a topical analgesic. The request as submitted failed to indicate a frequency. Given the above, the request is not medically necessary.

Unknown TENS patches: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-117.

Decision rationale: California MTUS Guidelines state transcutaneous electrotherapy is not recommended as a primary treatment modality, but a 1 month home based trial may be considered as a noninvasive conservative option. In this case, it is noted that the injured worker has continuously utilized a TENS unit. However, there is no documentation of how often the unit is used as well as outcomes in terms of pain relief or function. The medical necessity for the ongoing use of a TENS device has not been established in this case. Therefore, the current request is not medically necessary.