

<b>Case Number:</b>	CM15-0089216		
<b>Date Assigned:</b>	05/13/2015	<b>Date of Injury:</b>	01/24/2013
<b>Decision Date:</b>	07/03/2015	<b>UR Denial Date:</b>	04/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/08/2015

### 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, Hawaii

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 57 year old male, who sustained an industrial injury on 03/12/2013. He has reported injury to the right shoulder and right elbow. The diagnoses have included right shoulder acromioclavicular joint arthrosis, impingement, and rotator cuff tendinitis; status post right shoulder diagnostic and operative arthroscopy on 11/08/2013; and right elbow ulnar neuritis and multicompartamental osteophyte formation. Treatment to date has included medications, diagnostics, and surgical intervention. Medications have included Ultram ER, Voltaren XR, and Prilosec. A progress note from the treating physician, dated 05/05/2014, documented a follow-up visit with the injured worker. The injured worker reported range of motion and stiffness of the right shoulder continue to improve; and right elbow ulnar neuritis. Objective findings included right elbow audible crepitation with supination; and tenderness to the radial head and to the posterior olecranon tip. Request is being made for 12 sessions of aquatic therapy; H-Wave unit; 60 Prilosec 20 mg with 2 refills; and Voltaren XR 100 mg with 2 refills.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**12 sessions of aquatic therapy:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic therapy Page(s): 22, 98-99.

**Decision rationale:** The patient presents with diagnoses of right shoulder acromioclavicular joint arthrosis, impingement and rotator cuff tendinitis, status post right shoulder diagnostic and operative arthroscopy on 11/8/13 and right elbow ulnar neuritis and multicompartamental osteophyte formation. The current request is for 12 sessions of aquatic therapy. Given the minimal and dated clinical history provided, the medical basis for the treating physician's requested treatment is unknown. MTUS Guidelines state, "Recommended as an optional form of exercise therapy, where available, as an alternative to land-based physical therapy. Aquatic therapy (including swimming) can minimize the effects of gravity, so it is specifically recommended where reduced weight bearing is desirable, for example extreme obesity". Furthermore, MTUS Guidelines state that for Myalgia and myositis 9-10 visits are recommended over 8 weeks. For Neuralgia, neuritis and radiculitis 8-10 visits are recommended. In this case, as noted above, the clinical history provided for review does not document the physician's request or document the medical necessity for care. The current request is outside of the MTUS recommendation of 8-10 sessions. The request is not medically necessary.

**H-wave unit:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines H-wave stimulation (HWT) Page(s): 117-118.

**Decision rationale:** The patient presents with diagnoses of right shoulder acromioclavicular joint arthrosis, impingement and rotator cuff tendinitis, status post right shoulder diagnostic and operative arthroscopy on 11/8/13 and right elbow ulnar neuritis and multicompartamental osteophyte formation. The current request is for H-wave unit 60. Given the minimal and dated clinic history provided for review we do not know the medical basis for the treating physician's requested treatment. At present we do not know if the request is for a 30-day trial, a purchase, or for a trial of different time duration. MTUS Guidelines support a 30-day trial for neuropathic pain. However, there is no documentation that a trial of a TENS unit has been performed and there is no record in any of the reports provided that a TENS unit was ever prescribed. MTUS Guidelines state, not recommended as an isolated intervention, but a one-month home-based trial of H-Wave stimulation may be considered as a noninvasive conservative option for diabetic neuropathic pain (Julka, 1998) (Kumar, 1997) (Kumar, 1998), or chronic soft tissue inflammation if used as an adjunct to a program of evidence-based functional restoration, and only following failure of initially recommended conservative care, including recommended physical therapy (i.e., exercise) and medications, plus transcutaneous electrical nerve stimulation (TENS). In this case, there is no documentation of a failed trial of TENS and the request does not specify if this request is for a 30 day trial or purchase. The request is not medically necessary.

**60 Prilosec 20mg with 2 refills: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 68-69.

**Decision rationale:** The patient presents with diagnoses of right shoulder acromioclavicular joint arthrosis, impingement and rotator cuff tendinitis, status post right shoulder diagnostic and operative arthroscopy on 11/8/13 and right elbow ulnar neuritis and multicompartamental osteophyte formation. The current request is for Prilosec 20mg with 2 refills 60. Given the minimal and dated clinic history provided for review we do not know the medical basis for the treating physician's requested treatment. We do not know the patient's history of use, if any, of this medication. We do not know the efficacy of this medication for this patient. MTUS guidelines state Omeprazole is recommended with precautions, "(1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA)." Clinician should weigh indications for NSAIDs against GI and cardio vascular risk factors, determining if the patient is at risk for gastrointestinal events. In this case, there is no documentation of GI complaints and there is no discussion regarding prior usage and the efficacy of this medication as required by MTUS on page 60. The current request is not medically necessary.

**60 Voltaren XR 100mg with 2 refills: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Nonselective NSAIDs Page(s): 71.

**Decision rationale:** The patient presents with diagnoses of right shoulder acromioclavicular joint arthrosis, impingement and rotator cuff tendinitis, status post right shoulder diagnostic and operative arthroscopy on 11/8/13 and right elbow ulnar neuritis and multi-compartmental osteophyte formation. The current request is for Voltaren XR 100mg with 2 refills. Given the minimal and dated clinic history provided for review we do not know the medical basis for the treating physician's requested treatment. We do not know the patient's history of use, if any, of this medication. We do not know the efficacy of this medication for this patient. MTUS Guidelines state, Voltaren-XR should only be used as chronic maintenance therapy. In this case, there is no documentation provided to show the efficacy of prior NSAID usage. MTUS on page 60 requires documentation of analgesia and functional improvement with chronic pain medication usage. Furthermore, the ODG guidelines do not support the usage of Voltaren due to the risk profile. The current request is not medically necessary.

