

Case Number:	CM14-0149929		
Date Assigned:	09/18/2014	Date of Injury:	05/16/2014
Decision Date:	11/26/2014	UR Denial Date:	09/03/2014
Priority:	Standard	Application Received:	09/15/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 49 year-old female who reported right shoulder and elbow pain after falling on 5/16/2014. Acute radiographs were normal. She was diagnosed with strain/sprain of the elbow and shoulder. A subsequent right shoulder MRI on 7/17/2014 showed degenerative changes and minor rotator cuff tearing. A right elbow MRI on 7/18/2014 showed a partial thickness tear of the common extensor tendon origin. Medical reports from 5/19/2014 to 6/27/14 showed treatment with Ibuprofen, Flexeril, Norco, an elbow sleeve, physical therapy, and Kenalog IM injection. Shoulder range of motion remained limited and there was ongoing elbow pain. The injured worker apparently changed treating physicians as of 8/6/14. Per the 8/6/2014 Doctor's First Report, there was right shoulder and elbow pain, and depression. There was right shoulder tenderness, signs of shoulder impingement, right elbow medial epicondyle tenderness, and a positive Tinel's at the elbow. Diagnoses were right shoulder impingement, right elbow epicondylitis, right ulnar impingement, and mood disorder. The treatment plan included x-rays, MRIs, ESWT, FCE, chiropractic, acupuncture, DNA testing, toxicology testing, VsNCT, TENS/EMS unit, cold/hot therapy unit, and topical compounds. The work status was "temporarily totally disabled". Treatment notes from 8/15/2014 and 9/11/2014 list treatment with infrared, exercise, myofascial release, and electrical stimulation. A right shoulder MRI on 8/13/2014 showed degenerative joint disease. A right elbow MRI on 8/14/2014 was normal. A right elbow (2-view) x-ray study on 8/15/2014 showed osteophytes off the proximal ulna and medial epicondyle of the humerus. On 9/3/2014 Utilization Review certified 6 of 12 acupuncture sessions, and non-certified all of the other requests.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the Right Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208-209.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Magnetic resonance imaging (MRI)

Decision rationale: The medical records do not document red flag indications, failed conservative care, or pending surgery, as per the recommendations in the MTUS. Per the Official Disability Guidelines citation above, repeat imaging is indicated when there is a significant clinical change. The treating physician did not discuss the indications for repeating the prior shoulder MRI. A repeat right shoulder MRI is redundant and not medically necessary.

MRI of the Right Elbow: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 33-34.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 34. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Elbow, MRIs

Decision rationale: The medical records do not establish that this injured worker presents with red flag indications, failed conservative care, or pending surgery, per the MTUS indications. Per the Official Disability Guidelines citation above, repeat imaging is indicated when there is a significant clinical change. The treating physician did not discuss the indications for repeating the prior elbow MRI. A repeat right elbow MRI is redundant and not medically necessary.

X-ray of the Right Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 214.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-208.

Decision rationale: The medical records document that prior x-ray studies of the right shoulder and elbow were previously obtained, and revealed no acute bony abnormalities. The MTUS ACOEM guidelines recommend imaging when there is evidence of significant pathology and "red flag" conditions. The treating physician did not discuss the prior imaging results and reasons why repeat studies were necessary. No evidence of significant new pathology was presented. The repeat radiographs are redundant and not medically necessary.

X-ray of the Right Elbow: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 33.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 33.

Decision rationale: According to the California MTUS/ACOEM guidelines, ordering imaging results presumes that "The imaging study results will substantially change the treatment plan." No evidence was provided in this case that the radiographs were likely to change the treatment plan. The medical records document that prior x-ray studies of the right shoulder and elbow were previously obtained, and revealed no acute bony abnormalities. The MTUS recommends imaging when there is evidence of significant pathology and "red flag" conditions. The treating physician did not discuss the prior imaging results and reasons why repeat studies were necessary. No evidence of significant new pathology was presented. The repeat radiographs are redundant and not medically necessary.

Extracorporeal shockwave therapy (ESWT): Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 10 Elbow Disorders (Revised 2007) Page(s): 203, 30. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Elbow, Shockwave Therapy; Shoulder, Extracorporeal shock wave therapy (ESWT)

Decision rationale: According to the guidelines, ESWT is not generally recommended. The guidelines indicate this treatment may be considered for calcifying tendonitis of the shoulder. However, ESWT is otherwise not recommended for any other upper extremity condition. This patient does not have calcific tendonitis of the shoulder. The medical records do not establish that ESWT is medically necessary. Therefore, this request is not medically necessary.

Functional Capacity Evaluation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines, Chapter 7 (Independent Medical Examinations and Consultations)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation, Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 137-8, 81, 126. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness for Duty, Functional capacity evaluation (FCE)

Decision rationale: The ACOEM guidelines pages 137-8, in the section referring to Independent Medical Evaluations (which is not the context in this case), state "there is little scientific evidence confirming that functional capacity evaluations predict an individual's actual capacity to perform in the workplace" and "...it is problematic to rely solely upon the functional capacity evaluation results for determination of current work capability and restrictions". The MTUS for Chronic Pain and the Official Disability Guidelines recommend a functional capacity evaluation for Work Hardening programs, which is not the context in this case. The treating physician has not defined the components of the functional capacity evaluation. Given that there is no formal definition of a functional capacity evaluation, and that a functional capacity evaluation might refer to a vast array of tests and procedures, medical necessity for a functional capacity evaluation (assuming that any exists), cannot be determined without a specific prescription which includes a description of the intended content of the evaluation. The MTUS for Chronic Pain, in the Work Conditioning-Work Hardening section, mentions a functional capacity evaluation as a possible criterion for entry, based on specific job demands. The treating physician has not provided any information in compliance with this portion of the MTUS. The functional capacity evaluation in this case is not medically necessary based on lack of medical necessity and lack of a sufficiently specific prescription.

12 Acupuncture sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The prescription for acupuncture is evaluated in light of the MTUS recommendations for acupuncture. Per the MTUS, acupuncture is used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. The treating physician has not provided the specific indications for acupuncture as listed in the MTUS. There is no discussion of issues with pain medications, or functional recovery in conjunction with surgery and physical rehabilitation. An initial course of acupuncture is 3-6 visits per the MTUS. The prescription is for 12 visits, which exceeds the quantity recommended in the MTUS. Therefore, Acupuncture is not medically necessary.

12 Chiropractic manipulation treatments: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-59. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder; Elbow, Manipulation

Decision rationale: Per the MTUS for Chronic Pain, a trial of 6 visits of manual therapy and manipulation may be provided over 2 weeks, with any further manual therapy contingent upon functional improvement. The maximum recommended duration and number of visits is up to 18 visits over 6-8 weeks. 12 visits exceed the recommended initial course per the MTUS. Given that the focus of manipulative therapy is functional improvement, function (including work status or equivalent) must be addressed as a starting point for therapy. Given that the focus of manipulative therapy is functional improvement, "temporarily totally disabled" is not an appropriate starting point for therapy, and does not represent a sufficient emphasis on restoring function. No manual and manipulative therapy is medically necessary based on the lack of emphasis on functional restoration and a prescription which exceeds that recommended in the MTUS.

DNA testing: 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) Pain Genetic testing for potential opioid abuse

Decision rationale: The MTUS does not address DNA testing. Per the Official Disability Guidelines citation above, cytokine DNA testing is not recommended and lacks good medical evidence. Presumably cytokine DNA testing is what is referred to by the treating physician, as he has stated that this testing is to help treat chronic pain. The treating physician did not provide valid, alternative medical evidence to support this request. The DNA testing is not medically necessary based on guidelines and lack of evidence.

Toxicology testing: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic), Urine Drug Screen

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, drug screens, steps to avoid misuse/addiction Page(s): 43, 77, 78, 89, 94. Decision based on Non-MTUS Citation ACOEM Guidelines, 8/14/08, Chronic Pain, Page 138, urine drug screens

Decision rationale: According to the California MTUS guidelines, Urine toxicology screening should be considered for patients maintained on an opioid medication regimen when issues regarding dependence, abuse, or misuse are present. The treating physician has stated that toxicology testing is to monitor medications. No medications were specified with this request, and no current medications were listed in the medical report. Presumably the test is a urine drug test but this cannot be determined with certainty with the available records. Medical necessity for a urine drug screen is predicated on a chronic opioid therapy program conducted in accordance with the recommendations of the MTUS, or for a few other, very specific clinical reasons. There

is no evidence in this case of an opioid therapy program, and the treating physician has not listed any other reasons to do the urine drug screen. The request is not medically necessary based on lack of a specific request and the lack of any clear indications provided by the treating physician.

VSNCT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Current perception threshold (CPT) testing.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck, Quantitative sensory threshold (QST) testing; Current perception threshold (CPT) testing; Other Medical Treatment Guideline or Medical Evidence: AETNA - Quantitative Sensory testing methods (http://www.aetna.com/cpb/medical/data/300_399/0357.html)

Decision rationale: The California MTUS does not address VSNCT. According to the Official Disability Guidelines, quantitative sensory threshold (QST) testing/Current perception threshold (CPT) testing is not recommended. There are no clinical studies demonstrating that quantitative tests of sensation improve the management and clinical outcomes of patients over standard qualitative methods of sensory testing. According to the Aetna reference, voltage-actuated sensory nerve conduction threshold (VsNCT) testing (e.g., by means of the Medi-Dx 7000 or the Neural-Scan) is considered experimental and investigational because its clinical value has not been established in the peer-reviewed published medical literature. This electrodiagnostic testing is not medically necessary and not supported by the referenced guidelines.

TENS/EMS Unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic intractable pain. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); TENS, chronic pain (transcutaneous electrical nerve stimulation)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation)

Decision rationale: The MTUS for Chronic Pain lists the indications for TENS, which are primarily neuropathic pain, a condition not present in this patient. Other recommendations, including specific components of the treatment plan, are listed in the MTUS. The necessary kind of treatment plan is not present, including a focus on functional restoration with a specific trial of TENS alone. Given the lack of clear indications in this injured worker (primary reason), and the lack of any clinical trial or treatment plan per the MTUS (secondary reason), a TENS unit is not medically necessary. The MTUS recommends against EMS/neuromuscular electrical stimulation for chronic pain. This portion of the unit is therefore not medically necessary as well.

Hot and Cold therapy unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment, Chapter 9 Shoulder Complaints Page(s): 48, 204. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Continuous-flow cryotherapy; ACOEM Guidelines, Updated Chronic Pain Section, Page 166, 168; heat and cold therapies

Decision rationale: According to the MTUS, heat and cold packs are recommended as an option for acute pain. At-home local applications of cold packs in first few days of acute complaint; thereafter, applications of heat packs or cold packs. There is no recommendation for any specific device in order to accomplish this. Heat and cold can be applied to the skin using simple home materials, e.g. ice and hot water, without any formal medical device or equipment. Per Page 48 of the Guidelines, heat or cold may be used for two weeks or less. This patient's condition is long past the two-week duration. The updated ACOEM Guidelines for Chronic Pain are also cited. There may be some indication for heat therapy, but the recommendation is for home application of non-proprietary, low-tech, heat therapy in the context of functional restoration. There is no evidence of any current functional restoration program. According to the Official Disability Guidelines, short term continuous cryotherapy may be recommended as an option after surgery, but not for nonsurgical treatment. The hot and cold contrast therapy unit is not medically necessary based on guidelines.

1 prescription of Topical Compound Flurbiprofen 20%, Tramadol 15% #180gms: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical NSAID's (non-steroidal anti-inflammatory).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain, Topical Analgesics Page(s): 60, 111-113.

Decision rationale: Per the MTUS Chronic Pain Medical Treatment Guidelines, page 60, medications are to be given individually, one at a time, with assessment of specific benefit for each medication. Provision of multiple medications simultaneously is not recommended. In addition to any other reason for lack of medical necessity for these topical agents, they are not medically necessary on this basis at minimum. Topical NSAIDs for short term pain relief may be indicated for pain in the extremities caused by OA or tendonitis. This injured worker is also prescribed an oral NSAID and another topical NSAID, making a second topical NSAID duplicative and unnecessary, as well as possibly toxic. Note that topical Flurbiprofen is not FDA approved, and is therefore experimental and cannot be presumed as safe and efficacious. Non-FDA approved medications are not medically necessary. There is no standard or recognized use of tramadol in combination with an NSAID or for the conditions present in this injured worker. This topical compound is not medically necessary based on the guidelines discussed above, lack of medical evidence, FDA directives, and inappropriate prescribing.

1 prescription of Topical Compound Capsaicin 0.025%, Flurbiprofen 20%, Tramadol 15%, Menthol 2%, Camphor 2%, #180gms: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical NSAID's (non-steroidal anti-inflammatory).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain, Topical Analgesics Page(s): 60, 111-113.

Decision rationale: Per the MTUS Chronic Pain Medical Treatment Guidelines, page 60, medications are to be given individually, one at a time, with assessment of specific benefit for each medication. Provision of multiple medications simultaneously is not recommended. In addition to any other reason for lack of medical necessity for these topical agents, they are not medically necessary on this basis at minimum. Topical NSAIDs for short term pain relief may be indicated for pain in the extremities caused by OA or tendonitis. This injured worker is also prescribed an oral NSAID and another topical NSAID, making a second topical NSAID duplicative and unnecessary, as well as possibly toxic. Note that topical Flurbiprofen is not FDA approved, and is therefore experimental and cannot be presumed as safe and efficacious. Non-FDA approved medications are not medically necessary. There is no standard or recognized use of tramadol in combination with an NSAID or for the conditions present in this injured worker. Capsaicin has some indications, in the standard formulations readily available without custom compounding. It is not clear what the indication is in this case, as the injured worker does not appear to have the necessary indications per the MTUS. The MTUS also states that capsaicin is only recommended when other treatments have failed. This injured worker has not received adequate trials of other, more conventional treatments. The treating physician did not discuss the failure of other, adequate trials of other treatments. Capsaicin is not medically necessary based on the lack of indications per the MTUS. This topical compound is not medically necessary based on the guidelines discussed above, lack of medical evidence, FDA directives, and inappropriate prescribing.