

Case Number:	CM14-0131986		
Date Assigned:	08/22/2014	Date of Injury:	02/01/2009
Decision Date:	12/24/2014	UR Denial Date:	08/05/2014
Priority:	Standard	Application Received:	08/18/2014

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 Management 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 female patient with the date of injury of February 1, 2009. A Utilization Review dated August 5, 2014 recommended non-certification of right shoulder injection, urine toxicology, ECSWT left shoulder, ECSWT bilateral elbows, EMG/NCV bilateral upper extremities, consultation with psychologist, physical performance FCE, elbow sleeve, bilateral wrist brace, interferential unit, hot and cold unit, physical therapy evaluation and treatment bilateral shoulders, bilateral elbows, bilateral wrists, Fluriflex 180gm, and TGHOT 180gm. A Doctor's First Report dated July 23, 2014 identifies Subjective Findings of persistent symptoms that have not improved. The patient complains of pain in the elbows, shoulders, wrists and hands, psychiatric complaints, and sleeping problems. Examination identifies tenderness anteriorly and over the bilateral clavicles, biceps tendon groove, rotator cuff muscles, left shoulder tenderness posteriorly, decreased range of motion bilaterally, and positive Neer/Codman's test bilaterally. Examination of the bilateral elbows showed tenderness anteriorly/laterally, medially with positive Cozen's/Mill's test/Tinel's bilaterally. Bilateral wrists tenderness is noted over the palmar and dorsal aspects and positive Tinel's and Phalen's test bilaterally. Diagnoses identify sprains and strains of unspecified site of shoulder and upper arm. Treatment Plan identifies Fluriflex 180 GM, TGHOT 180 GM, elbow sleeve, bilateral wrist brace, interferential unit, hot and cold unit, ECSWT for the left shoulder and bilateral elbows, EMG/NCV of the upper extremities, consultation with psychologist, and physical performance capacity evaluation. The claimant was injected with shoulder injection and urine toxicology was administered.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right shoulder injection: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Shoulder Page(s): 204. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder

Decision rationale: Regarding the request for right shoulder injection, Chronic Pain Medical Treatment Guidelines support the use of a subacromial injection if pain with elevation significantly limits activity following failure of conservative treatment for 2 or 3 weeks. It goes on to recommend the total number of injections should be limited to 3 per episode, allowing for assessment of benefits between injections. Official Disability Guidelines recommend performing shoulder injections guided by anatomical landmarks alone. Guidelines go on support the use of corticosteroid injections for adhesive capsulitis, impingement syndrome, or rotator cuff problems which are not controlled adequately by conservative treatment after at least 3 months, when pain interferes with functional activities. Guidelines state that a 2nd injection is not recommended if the 1st has resulted in complete resolution of symptoms, or if there has been no response. Within the documentation available for review, there is no indication of pain with elevation that significantly limits activity following failure of conservative treatment for 2 or 3 weeks. As such, the currently requested right shoulder injection is not medically necessary.

Urine toxicology: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 76-79 and 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chronic Pain Chapter, Urine Drug Testing

Decision rationale: Regarding the request for urine toxicology, CA MTUS Chronic Pain Medical Treatment Guidelines state that drug testing is recommended as an option. Guidelines go on to recommend monitoring for the occurrence of any potentially aberrant (or nonadherent) drug related behaviors. ODG recommends urine drug testing on a yearly basis for low risk patients, 2-3 times a year for moderate risk patients, and possibly once per month for high risk patients. Within the documentation available for review, it does not appear that the patient is on controlled substance medication or is at risk of illegal substance use, and there is no other documented indication for performing urine toxicology. As such, the currently requested urine toxicology is not medically necessary.

Extracorporeal shockwave therapy (ECSWT) left shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines), Extracorporeal Shockwave Therapy

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Extracorporeal Shockwave Therapy (ESWT)

Decision rationale: Regarding the request for ECSWT left shoulder, ODG recommend for calcifying tendinitis but not for other shoulder disorders. In treating calcifying tendonitis, both high-energy and low-energy ESWT provide a beneficial effect on shoulder function, as well as on self-rated pain and diminished size of calcifications, but high-energy ESWT appears to be superior to low-energy ESWT. There is no evidence of benefit in non-calcific tendonitis of the rotator cuff, or other shoulder disorders, including frozen shoulder or breaking up adhesions. The criteria for use of ESWT includes: Patients whose pain from calcifying tendinitis of the shoulder has remained despite six months of standard treatment; At least three conservative treatments have been performed prior to use of ESWT. These would include: a. Rest, b. Ice, c. NSAIDs, d. Orthotics, e. Physical Therapy, e. Injections (Cortisone); Contraindicated in Pregnant women; Patients younger than 18 years of age; Patients with blood clotting diseases, infections, tumors, cervical compression, arthritis of the spine or arm, or nerve damage; Patients with cardiac pacemakers; Patients who had physical or occupational therapy within the past 4 weeks; Patients who received a local steroid injection within the past 6 weeks; Patients with bilateral pain; Patients who had previous surgery for the condition. Within the documentation available for review, there is no identification of a diagnosis of right shoulder calcifying tendinitis. As such, the current request for ECSWT left shoulder is not medically necessary.

Extracorporeal shockwave therapy (ECSWT) bilateral elbows: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines), Extracorporeal Shockwave Therapy

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 29. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Elbow, Extracorporeal shockwave therapy (ESWT)

Decision rationale: Regarding the request for ECSWT bilateral elbows, Occupational Medicine Practice Guidelines state quality studies are available on extracorporeal shockwave therapy in acute, subacute, and chronic lateral epicondylalgia patients and benefits have not been shown. This option is moderately costly, has some short-term side effects, and is not invasive. Thus, there is a recommendation against using extracorporeal shockwave therapy. ODG states extracorporeal shockwave therapy is not recommended. High energy ESWT is not supported, but low energy ESWT may show better outcomes without the need for anesthesia, but is still not recommended. Trials in this area have yielded conflicting results. The value, if any, of ESWT for lateral elbow pain, can presently be neither confirmed nor excluded. After other treatments have failed, some providers believe that shock-wave therapy may help some people with heel pain and

tennis elbow. However, recent studies do not always support this, and ESWT cannot be recommended at this time for epicondylitis, although it has very few side effects. As such, the currently requested ECSWT bilateral elbows is not medically necessary.

EMG/NCV bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines), Neck and Upper Back Procedure Summary

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178 and 182. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck Chapter, Electrodiagnostic Studies, Electromyography, Nerve Conduction Studies

Decision rationale: Regarding the request for EMG/NCV bilateral upper extremities, Occupational Medicine Practice Guidelines state that the electromyography and nerve conduction velocities including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. Within the documentation available for review, there are no recent physical examination findings identifying subtle focal neurologic deficits, for which the use of electrodiagnostic testing would be indicated. In the absence of such documentation, the currently requested EMG/NCV bilateral upper extremities is not medically necessary.

Consultation with psychologist: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 100-102. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chronic Pain, Behavioral Interventions

Decision rationale: Regarding the request for consultation with psychologist, Chronic Pain Medical Treatment Guidelines state that psychological evaluations are recommended. Psychological evaluations are generally accepted, well-established diagnostic procedures not only with selected using pain problems, but also with more widespread use in chronic pain populations. Diagnostic evaluations should distinguish between conditions that are pre-existing, aggravated by the current injury, or work related. Psychosocial evaluations should determine if further psychosocial interventions are indicated. ODG states the behavioral interventions are recommended. Guidelines go on to state that an initial trial of 3 to 4 psychotherapy visits over 2 weeks may be indicated. Within the documentation available for review, there are no subjective complaints of psychological issues, no mental status exam, and no indication of what is intended to be addressed with the currently requested psychological consultation. In the absence of clarity regarding those issues, the currently requested consultation with psychologist is not medically necessary.

Physical performance FCE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional Improvement Measures. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines) Fitness for Duty Procedure Summary

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 1 Prevention Page(s): 12. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Fitness for Duty Chapter, Functional Capacity Evaluation

Decision rationale: Regarding the request for physical performance FCE, Occupational Medicine Practice Guidelines state that there is not good evidence that functional capacity evaluations are correlated with a lower frequency of health complaints or injuries. ODG states that functional capacity evaluations are recommended prior to admission to a work hardening program. The criteria for the use of a functional capacity evaluation includes case management being hampered by complex issues such as prior unsuccessful return to work attempts, conflicting medical reporting on precautions and/or fitness for modified job, or injuries that require detailed explanation of a worker's abilities. Additionally, guidelines recommend that the patient be close to or at maximum medical improvement with all key medical reports secured and additional/secondary conditions clarified. Within the documentation available for review, there is no indication that there has been prior unsuccessful return to work attempts, conflicting medical reporting, or injuries that would require detailed exploration. In the absence of clarity regarding those issues, the currently requested physical performance FCE is not medically necessary.

Elbow sleeve: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines), Splinting for Epicondylitis

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

Decision rationale: Regarding the request for elbow sleeve, California MTUS does not address the issue. ODG states it is recommended for cubital tunnel syndrome (ulnar nerve entrapment), including a splint or foam elbow pad worn at night (to limit movement and reduce irritation), and/or an elbow pad (to protect against chronic irritation from hard surfaces). Within the documentation available for review, there is no documentation of cubital tunnel syndrome. In the absence of such documentation, the currently requested elbow sleeve is not medically necessary.

Bilateral wrist brace: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines), Splinting of the Wrist

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

Decision rationale: Regarding the request for bilateral wrist brace, California MTUS does support splinting as a first-line conservative treatment for multiple wrist/hand conditions. Within the documentation available for review, there is no clear rationale identifying why a brace is necessary for this patient. In the absence of such documentation, the currently requested bilateral wrist brace is not medically necessary.

Interferential unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-120.

Decision rationale: Regarding the request for interferential unit, CA MTUS Chronic Pain Medical Treatment Guidelines state that "interferential current stimulation is not recommended as an isolated intervention." It goes on to state that "patient selection criteria if interferential stimulation is to be used anyways include pain is ineffectively controlled due to diminished effectiveness of medication, side effects or history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercises, or unresponsive to conservative treatment." If those criteria are met, then a one month trial may be appropriate to study the effects and benefits. With identification of objective functional improvement, additional interferential unit use may be supported. Within the documentation available for review, there is no indication that the patient has met the selection criteria for interferential stimulation (pain is ineffectively controlled due to diminished effectiveness of medication, side effects or history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercises, or unresponsive to conservative treatment.). Additionally, there is no documentation that the patient has undergone an interferential unit trial with objective functional improvement and there is no provision for modification of the current request. In light of the above issues, the currently requested interferential unit is not medically necessary.

Hot and Cold unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Carpal Tunnel Syndrome Chapter, Cold packs and Heat Therapy

Decision rationale: Regarding the request for hot and cold unit, California MTUS and ODG do support the use of simple heat/cold packs. However, more sophisticated treatment is not supported except in the first 7 days following surgical intervention. Within the documentation available for review, there is no documentation supportive of the need for specialized hot and cold units rather than simple heat/cold packs. In the absence of such documentation, the currently requested hot and cold unit is not medically necessary.

Physical therapy evaluation and treatment bilateral shoulders, bilateral elbows, bilateral wrists two (2) times a week for six (6) weeks: Upheld

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

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

Decision rationale: Regarding the request for physical therapy evaluation and treatment bilateral shoulders, bilateral elbows, bilateral wrists two (2) times a week for six (6) weeks, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of 6 physical therapy visits. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, there is no indication of any specific objective treatment goals and no statement indicating why an independent program of home exercise would be insufficient to address any objective deficits. Furthermore, the request exceeds the amount of PT recommended by the CA MTUS for an initial trial and, unfortunately, there is no provision for modification of the current request. In the absence of such documentation, the current request for physical therapy evaluation and treatment bilateral shoulders, bilateral elbows, bilateral wrists two (2) times a week for six (6) weeks is not medically necessary.

Fluriflex 180gm: Upheld

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

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

Decision rationale: Regarding the request for topical flurbiprofen, guidelines state that topical NSAIDs are recommended for short-term use. Oral NSAIDs contain significantly more guideline

support, provided there are no contraindications to the use of oral NSAIDs. Regarding the request for topical cyclobenzaprine, Chronic Pain Medical Treatment Guidelines state that topical muscle relaxants are not recommended. They go on to state that there is no evidence for the use of any muscle relaxants as a topical product. Therefore, in the absence of guideline support for topical muscle relaxants, the currently requested Fluriflex is not medically necessary.

TGHot 180gm: Upheld

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

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

Decision rationale: Regarding the request for TGHot cream, California MTUS cites that capsaicin is "Recommended only as an option in patients who have not responded or are intolerant to other treatments." Topical gabapentin is not supported by the CA MTUS for topical use. Within the documentation available for review, none of the abovementioned criteria have been documented. Furthermore, there is no clear rationale for the use of topical medications rather than the FDA-approved oral forms for this patient. In light of the above issues, the currently requested TGHot cream is not medically necessary.