

Case Number:	CM13-0039207		
Date Assigned:	03/28/2014	Date of Injury:	07/18/2013
Decision Date:	07/14/2014	UR Denial Date:	09/16/2013
Priority:	Standard	Application Received:	10/03/2013

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 Neurological Surgery 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:

The injured worker is a 58-year-old female noted to have sustained a cumulative trauma type injury in June 2010 to July 2013 due to work related cumulative trauma. The primary diagnosis is noted as pain in the shoulder, pain in the upper arm, sprain/strain of the elbow, carpal tunnel syndrome, and low back sprain. Multiple topical preparations, additional imaging studies, and repeat electrodiagnostic assessments were not certified. The August 23, 2013 report identified complaints involving the head, neck, chest, bilateral shoulders, bilateral elbows, bilateral wrists, hands, low back, hips, bilateral knees, and left ankle. The pain is described as moderate to severe, 7/10 on the visual analog scale (VAS). At the time of that report, there is no objectification that any of the interventions have achieved amelioration of the symptomology. Physical examination noted a decrease in cervical spine range of motion and a decrease in the range of motion of all involved joints. A slight sensory loss noted throughout the bilateral upper extremities and a slight motor loss is also reported. The diagnoses include a cervical radiculopathy, bilateral shoulder sprain/strain, elbow sprain/strain, bilateral carpal tunnel syndrome, difficulty breathing, a lumbar sprain/strain, and internal arrangement of the left knee and ankle. Multiple medications were prescribed. A follow-up progress note completed in September of 2013 noted the same level of pain complaints, the same findings on physical examination, and no improvement in the overall clinical situation reported. A psychiatric evaluation was completed in October of 2013. A letter of medical necessity was issued in December of 2013 in support of the multiple medications that were not certified as being clinically indicated on a prior review. In December of 2013, the injured worker complains of depression, anxiety, and insomnia. The January 2014 follow-up clinical evaluation noted the pain complaints to be 7-9/10 on the VAS and the multiple areas involved. An additional letter of medical necessity was submitted. The follow-up physical examination completed in February

2014 noted the injured worker to be "in no acute distress." The physical examination reported is essentially unchanged from the prior three assessments. The diagnosis list was unchanged. The same medications were prescribed.

IMR ISSUES, DECISIONS AND RATIONALES

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

COMPOUND KETOPROFEN 20% IN PLO GEL 120GMS: 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.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that the topical utilization of a non-steroidal is largely experimental and given that the multiple progress notes presented do not indicate any efficacy, utility, improvement or functional gains and that the pain levels continue to be equal to or greater than 7/10 on the VAS. There is no indication that this is an appropriate intervention. This medication is not recommended by guidelines. Therefore, the requested Ketoprofen is not medically necessary.

COMPOUND CYCLOPHENE 5% IN PLO GEL 120GMS: 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 Page(s): 111.

Decision rationale: When considering the date of injury, the reported mechanism of injury, complete lack of any clinical improvement or reduction in pain complaints, the ongoing use of this medication is not clinically supported. This topical preparation is experimental and not recommended by the Chronic Pain Medical Treatment Guidelines. Therefore, the requested Cyclophene gel is not medically necessary.

SYNAPRYN 10MG/1ML ORAL SUSPENSION 500ML: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 86.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, the use of opioids for chronic pain is significantly limited particularly when there is no clinical indication of any efficacy, utility or functional improvement. This is an individual who has multiple complaints and has had no positive response to any of the interventions. As such, there is no clinical indication to continue such a medication without the benefit of a positive response. Therefore, the requested Synapryn is not medically necessary.

TABRADOL 1MG/1ML ORAL SUSPENSION 250ML: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 86.

Decision rationale: This is an oral suspension of the medication Tramadol. According to the Chronic Pain Medical Treatment Guidelines, the use of opioids for chronic pain is significantly limited particularly when there is no clinical indication of any efficacy, utility or functional improvement. This is an individual who has multiple complaints and has had no positive response to any of the interventions. As such, there is no clinical indication to continue such a medication without the benefit of a positive response. Therefore, the requested Tabradol is not medically necessary.

DEPRIZINE 15MG/1ML ORAL SUSPENSION 250ML: Overturned

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

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

Decision rationale: The individual in this case has had multiple complaints, multiple medications, and ongoing issues. Deprizine is being requested to address the gastrointestinal distress and is clinically indicated according to guidelines. Therefore, the requested Deprizine is medically necessary.

DICOPANOL 5MG/1ML ORAL SUSPENSION 150 ML: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) FORMULARY CHAPTER.

Decision rationale: This is an oral suspension of the medication Benadryl. This can be used in insomnia treatment the injured worker is experiencing, however, there is nothing in the progress notes indicating a chronic insomnia malady. Therefore, the requested Dicoplanol is not medically necessary.

GABAPENTIN 25MG/1ML ORAL SUSPENSION 420ML: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 64.

Decision rationale: While noting that there are generalized pain complaints, and none of these complaints have been ameliorated with any of the interventions. Therefore, the continued use of Gabapentin is not supported by the guidelines. Therefore, the requested Gabapentin is not medically necessary.

X-RAYS (BODY PART UNSPECIFIED): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: It is not clear what body parts are to be imaged with this request. This complete lack of clinical information does not support the use of this preparation.

TENS UNIT WITH SUPPLIES: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-116.

Decision rationale: When considering the date of injury, the insidious onset of the pain complaints, and the complete lack of any resolution of the symptomology's with any intervention there is no data presented to suggest that this type of device would have any type of efficacy or utility. In addition, a trial in a controlled environment has not been reported, which is

recommended by the guidelines. Therefore, the requested TENS unit and supplies are not medically necessary.

HOT/COLD UNIT (RENTAL/PURCHASE UNSPECIFIED) QTY:1.00: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 162.

Decision rationale: The ACOEM guidelines recommend hot/cold interventions for acute injuries only. When noting the diffuse nature of the complaints, the insidious onset, and a generalized overall complaints without any response to medications, there is no clinical indication for a hot/cold pack at this time. Therefore this requested hot/cold unit is not medically necessary.

SHOCKWAVE THERAPY: 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) ELBOW CHAPTER.

Decision rationale: The Official Disability Guidelines (ODG) was reviewed for shockwave therapy. However, the diagnosis this therapy is indicated for is not present for the injured worker and there is no evidence of benefit in noncalcific tendinitis. Therefore, the requested shockwave therapy is not medically necessary.

EMG/NCV: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: The location and nature of the study requested is not specified. Therefore, the requested EMG/NCV is not medically necessary.

MRI (BODY PART UNSPECIFIED): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: The location and nature of the study requested is not specified. Therefore, the requested MRI Is not medically necessary.