

Case Number:	CM13-0047868		
Date Assigned:	12/27/2013	Date of Injury:	06/18/2013
Decision Date:	02/24/2014	UR Denial Date:	10/16/2013
Priority:	Standard	Application Received:	11/04/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Emergency Medicine and is licensed to practice in New York and Tennessee. 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 physician 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 patient is a 51-year-old female who was injured on June 18, 2013 when she fell over the trash cart she was pushing after it got hung up on the pavement. The patient continued to experience pain in her neck, back, and left shoulder. The physical examination revealed tenderness to the lumbar paraspinal muscles. There were no sensory or motor deficits. The diagnoses included cervical strain, left shoulder and trapezius strain, and thoracolumbar strain. The treatment included physical therapy and medications. There is no documentation regarding degree of functional improvement with physical therapy. The patient underwent arthroscopic surgery on September 24, 2013 for left shoulder impingement and left rotator cuff repair. There was concern for the patient's narcotic use. The patient was evaluated on September 24, 2013 for frequent neck pain, constant mid-back pain, occasional low back pain, and constant left shoulder pain. At that time requests for authorization for acupuncture twice weekly for 4 weeks, physical therapy twice weekly for 4 weeks for the cervical spine, lumbar spine, and left shoulder, extracorporeal shockwave lithotripsy, Flurbiprofen #180, Somnicin 2-56-2-100 # 30, urinalysis every 4-6 weeks, New terocin0.25-.25 # 240, and Hot/cold unit were submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Acupuncture, twice weekly for four weeks for the cervical spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: Acupuncture is used as an option when pain medication is reduced or not tolerated or as an adjunct to physical rehabilitation. It is the insertion and removal of filiform needles to stimulate acupoints (acupuncture points). Needles may be inserted, manipulated, and retained for a period of time. Acupuncture can be used to reduce pain, reduce inflammation, increase blood flow, increase range of motion, decrease the side effect of medication-induced nausea, promote relaxation in an anxious patient, and reduce muscle spasm. Acupuncture with electrical stimulation is the use of electrical current on the needles at the acupuncture site. It is used to increase effectiveness of the needles by continuous stimulation of the acupoint. Physiological effects (depending on location and settings) can include endorphin release for pain relief, reduction of inflammation, increased blood circulation, analgesia through interruption of pain stimulus, and muscle relaxation. It is indicated to treat chronic pain conditions, radiating pain along a nerve pathway, muscle spasm, inflammation, scar tissue pain, and pain located in multiple sites. Specific indications for treatment of pain include treatment of joint pain, joint stiffness, soft tissue pain and inflammation, paresthesias, post-surgical pain relief, muscle spasm and scar tissue pain. OGD states that acupuncture is not recommended for acute back pain, but is recommended as an option for chronic low back pain in conjunction with other active interventions. Acupuncture is recommended when use as an adjunct to active rehabilitation.

Physical therapy twice weekly for four weeks for the cervical spine, lumbar spine and left shoulder: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Preface, Physical Therapy Guidelines.

Decision rationale: Chronic Pain Medical Treatment Guidelines state that there is no high-grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction, heat/cold applications, massage, diathermy, TENS units, ultrasound, laser treatment, or biofeedback. They can provide short-term relief during the early phases of treatment. Active treatment is associated with better outcomes and can be managed as a home exercise program with supervision. ODG states that physical therapy is more effective in short-term follow up. Patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy). When treatment duration and/or number of visits exceed the guideline, exceptional factors should be noted. In this case the patient was not in the early phases of treatment. There is no baseline functional assessment to determine therapy goals and no plan for reassessment after 6 visits to determine if the therapy is improving the patient's condition. The patient has been treated with physical therapy shortly after her injury with little benefit. Medical benefit is not established.

Extracorporeal shockwave lithotripsy: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back- Thoracic and Lumbar, Shock Wave Therapy.

Decision rationale: Shock wave therapy is not recommended. The available evidence does not support the effectiveness of ultrasound or shock wave for treating LBP. In the absence of such evidence, the clinical use of these forms of treatment is not justified and should be discouraged

Flurbiprofen #180: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, Specific Drug List & Adverse Effects Section and Topical Analgesics Section Page(s): 72,.

Decision rationale: Flurbiprofen is a non-steroidal anti-inflammatory drug recommended as an oral agent for osteoarthritis and mild to moderate pain. Topical NSAIDs have been shown to be superior to placebo in the treatment of osteoarthritis, but only in the short term and not for extended treatment. The effect appears to diminish over time. Absorption of the medication can occur and may have systemic side effects comparable to oral form. Adverse effects for GI toxicity and renal function have been reported. It has not been evaluated for treatment of the spine, hip, or shoulder. This patient had not been diagnosed with osteoarthritis. There is no medical indication for topical NSAID use.

Sominicin 2-50-100mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Neck and Upper Back

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Melatonin, Medical Foods, Vitamin B.

Decision rationale: Sominicin is an over the counter (OTC) combination sleep aid medication containing melatonin, tryptophan, vitamin B6, magnesium, and hydroxytryptophan. Hydroxytryptophan has been found to be possibly effective in treatment of anxiety disorders, fibromyalgia, obesity and sleep disorders. It has been found to be effective for depression. In alternative medicine it has been used for depression, anxiety, insomnia, obesity, aggressive behavior, eating disorders, fibromyalgia, chronic headaches and various pain disorders. It should be used with caution in individuals using SSRI antidepressants. Melatonin is recommended.

There are experimental and clinical data supporting an analgesic role of melatonin. In published studies melatonin shows potent analgesic effects in a dose-dependent manner, and melatonin has been shown to have analgesic benefits in patients with chronic pain. Also, the repeated administration of melatonin improves sleep and thereby may reduce anxiety, which leads to lower levels of pain. Vitamin B is not recommended. Vitamin B is frequently used for treating peripheral neuropathy but its efficacy is not clear. A recent meta-analysis concluded that there are only limited data in randomized trials testing the efficacy of vitamin B for treating peripheral neuropathy and the evidence is insufficient to determine whether vitamin B is beneficial or harmful. There is no comment in ODG in tryptophan or magnesium. The lack of information does not allow determination for medical necessity and safety and they cannot be recommended. The guidelines state that "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." Not all the components of this compounded medication are recommended and Sominicin is therefore not recommended.

Urinalysis every 4 to 6 weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Neck and Upper Back.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Urine Drug testing.

Decision rationale: Chronic Pain Medical Treatment Guidelines state that urinary drug testing should be used if there are issues of abuse, addiction, or pain control in patients being treated with opioids. ODG criteria for Urinary Drug testing are recommended for patients with chronic opioid use. Patients at low risk for addiction/aberrant behavior should be tested within 6 months of initiation of therapy and yearly thereafter. Those patients with moderate risk for addiction/aberrant behavior should undergo testing 2-3 times/year. Patients with high risk of addiction/aberrant behavior should be tested as often as once per month. In this case the patient had 3 urine drug tests which were positive only for the prescribed medications. She does not display high risk addiction/aberrant behaviors, such as observed intoxication, craving and preoccupation, or selling or forging prescriptions. Medical necessity for urine drug screening every 3-46 weeks is not established.

New Terocin 0.025%-25% #240: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines, Capsaicin Section, Salicylate Topicals Section, Topical Analg.

Decision rationale: New Terocin is a topical multidrug compound, which contains methylsalicylate, capsaicin, and menthol. Per Chronic Pain Medical Treatment Guidelines, only one medication should be given at a time and a trial should be given for each individual medication. Topical analgesics are recommended for neuropathic pain when anticonvulsants and

antidepressants have failed. Compounded topical analgesics are commonly prescribed and there is little to no research to support the use of these compounds. Furthermore, the guidelines state that "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." Capsaicin is recommended only as an option in patients who have not responded or cannot tolerate other treatments. It is recommended for osteoarthritis, fibromyalgia, and chronic non-specific back pain and is considered experimental in high doses. Methylsalicylate is a topical salicylate and is recommended, being significantly better than placebo in chronic pain. There are no guidelines present for menthol. In this case the patient received multidrug compound for medication. This is not consistent with the recommendation for only one medication should be given at a time. The topical compound is not medically necessary in this case.

Hot/Cold unit: 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)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Cold/Heat Packs.

Decision rationale: Cold/heat packs are recommended as an option for acute pain. Cold packs are recommended in the first few days after an acute complaint. Continuous flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Continuous low-level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. This patient was no longer in the acute phase of her treatment. There is no indication for cold therapy. Heat therapy may be beneficial but this does not require a Hot/cold unit for implementation of therapy. Medical necessity is not established for purchase of this device.