MAXIMUS Federal Services

Case Number:	CM13-0048832		
Date Assigned:	12/27/2013	Date of Injury:	03/12/2005
Decision Date:	04/03/2014	UR Denial Date:	10/29/2013
Priority:	Standard	Application Received:	11/06/2013

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 Physical Medicine & Rehabilitation, has a subspecialty in Interventional Spine 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 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 54-year-old male with a date of injury of 03/12/2005. The listed diagnoses per [redacted] dated 10/16/2013 are: (1) Right shoulder pain, (2) Right-sided medial epicondylitis, (3) Rotator cuff tear, (4) Disputed low back pain and bilateral upper extremity symptoms, (5) Status post carpal tunnel release and De Quervain's tenosynovectomy, 05/19/2008, (6) Adhesive capsulitis, (7) Residual focal entrapment neuropathies, (8) Significant intraarticular shoulder injury, (9) Worsening symptoms of upper extremity complaints. According to report dated 10/16/2013, the patient presents for a followup evaluation of back and upper limb pain. Back pain is described as aching, burning, tearing, and throbbing. The patient also complains of upper limb pain, which she describes as aching with movement and stiffness. It was noted that the pain was located in the right distal inner arm, right palmar hand, and anterior aspect of the right shoulder. The patient also complains of cervical pain, described as radicular pain in right and left arm, and weakness in right and left arm. Pain is noted as aching, pulling, radiating, and shooting. The patient also complains of thoracic pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

A spinal cord stimulator trial: 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 Spinal Cord Stimulation Page(s): 105-107. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Spinal Cord Stimulator

Decision rationale: This patient presents with complaints of back pain. The treating physician is requesting a SCS. Unfortunately, [redacted] report was not provided for review. Under spinal cord stimulation MTUS Guidelines page 105 to 107 states that it is recommended only for selected patients in cases when less invasive procedures have failed or are contraindicated for specific conditions and following a successful temporary trial. ODG Guidelines regarding spinal cord stimulator also states for failed back syndrome, persistent and pains who have undergone at least 1 previous back operation and are not candidates for repeat surgery when all of the following are present: (1) Symptoms of primarily lower extremity radicular pain, there has been limited response to nonintervention care, (2) Psychological clearance indicates realistic expectations and clearance for procedure, (3) There is no current evidence of substance abuse issues, (4) There are no contraindications to a trial, (5) Permanent placement requires evidence of 50% pain relief. In this case, the patient does not meet any of the criteria recommended by MTUS or ODG for a trial of stimulator. The patient does not have a diagnosis of failed back syndrome, no significant leg symptoms, and no clearance from a psychologist. Furthermore, there is no evidence of radicular pain in the lower extremities. The requested SCS is not medically necessary, and recommendation is for denial.

Physical therapy (18 sessions): 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 Physical Medicine Page(s): 98-99.

Decision rationale: This patient presents with complaints of back pain. The physician is requesting 18 physical therapy sessions. For physical medicine, the MTUS Guidelines recommend for myalgia- and myositis-type symptoms 9 to 10 visits over 8 weeks. In this case, review of records dated from 01/10/2013 to 10/16/2013 indicate that this patient has not had any physical therapy in the recent past. However, the requested 18 sessions exceeds what is recommended by MTUS Guidelines. Therefore, recommendation is for denial.

Topical Flector patch: 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 Topical Analgesics Page(s): 111-113.

Decision rationale: This patient presents with complaints of back pain. The physician is requesting Flector patches. The MTUS Guideline has the following regarding topical creams: for nonsteroidal antiinflammatory agents, the efficacy in clinical trials for this treatment modality has been inconsistent and most studies are short and small of duration. Topical NSAIDS have been shown at Meta Analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis. Indications for use are osteoarthritis and tendinitis in particular that of the knee and elbow or other joints that are amenable to topical cream. In this case, the patient does not meet the indication for this topical medication as he does not present with any osteoarthritis or tendinitis symptoms. The requested Flector patches are not medically necessary, and recommendation is for denial.

Percocet 5/325mg: 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 Opioids Page(s): 88-89.

Decision rationale: For chronic opiate use, MTUS Guidelines require functioning documentation using a numerical scale or a validated instrument at least once every 6 months. Documentation of the 4 As (analgesia, ADLs, adverse side effects, and adverse behaviors) is required. Furthermore, under outcome measures, it also recommends documentation of current pain, average pain, least pain, time it takes for medication to work, duration of pain relief with medication, etc. In this case, report dated 09/24/2013 states patient is taking Norco, then on report dated 10/16/2013, the physician recommends Percocet 5/325 #180. The efficacy of Norco was never discussed in any of the reports dated from 01/10/2013 to 09/24/2013, nor was there any reasoning or discussion for the need of change in medication from Norco to Percocet. Given the lack of discussions regarding pain relief or functional improvement from opiate use, the requested Percocet is not medically necessary, and recommendation is for denial.