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| Case Number: | CM13-0059117 | | |
| Date Assigned: | 03/31/2014 | Date of Injury: | 07/11/1986 |
| Decision Date: | 05/26/2014 | UR Denial Date: | 10/22/2013 |
| Priority: | Standard | Application Received: | 11/25/2013 |

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 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 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 patient is a 45 year old female with an injury date of 07/11/86- 05/21/13. Based on the 10/04/13 progress report by [REDACTED] the patient's diagnosis include the following: 1) Hand/wrist tenosynovitis BI 2) Grade three spondylolisthesis 3) Multilevel herniated discs C/S 4) Thoracalgia 5) Thoracic and lumbar myalgia/myofascitis 6) Lumbar facet syndrome R/O HNP 7) Probable post-traumatic headaches, anxiety, and insomnia 8) Probable gastritis from meds The MRI dated 08/01/13 showed disc dessication at C2-C3 down to C6-C7 and a focal disc herniation at C4-C5 and C5-C6 which causes stenosis of the spinal cord. There was also disc dessication at L5-S1, grade III spondylolytic anterolisthesis of L5 over S1, and a pseudodisc bulge at L5-S1 which causes bilateral neural foraminal and spinal canal stenosis. [REDACTED] is requesting the following: 1) 12 cupping acupuncture sessions 2) 12 electro acupuncture sessions 3) 12 infrared lamp treatments 4) Prilosec/Omeprazole 20 mg 5) Prozac/Fluoxetine 20 mg 6) Flurbiprofen compounded transdermal cream 7) Tramadol compounded transdermal cream 8) Cyclobenzaprine-gabapentin compounded transdermal cream The utilization review determination being challenged is dated 10/22/13 and recommends denial of all eight requests listed above. [REDACTED] is the requesting provider, and he provided treatment reports from 06/28/13- 10/04/13.

IMR ISSUES, DECISIONS AND RATIONALES

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

TWELVE (12) CUPPING ACUPUNCTURE SESSIONS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation

http://www.dir.ca.gov/dwc/DWCPropRegs/MedicalTreatmentUtilizationSchedule/MTUS_FinalCleanCopy.doc.

Decision rationale: According to the 10/04/13 progress report by [REDACTED], the patient presents with neck pain, back pain, and wrist pain presented with decreased range of motion and muscle spasms. The request is for 12 cupping acupuncture sessions. Review of the reports do not show any prior acupuncture reports and it is not known whether or not the patient has had acupuncture in the past. A search of the MTUS does not address cupping; therefore, guidelines regarding acupuncture, in general, were consulted. MTUS acupuncture guidelines recommend initial trial of 3-6 sessions of acupuncture. The current request for 12 sessions exceeds initial trial of 3-6 sessions recommended by MTUS. Additional treatments are recommended if the initial trial proves to be helpful in terms of functional improvement. Recommendation is for denial. The twelve (12) cupping Acupuncture sessions is not medically necessary and appropriate.

TWELVE (12) ELECTRO ACUPUNCTURE SESSIONS: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation 9792.20 Medical Treatment Utilization Schedule--Definitions.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation

http://www.dir.ca.gov/dwc/DWCPropRegs/MedicalTreatmentUtilizationSchedule/MTUS_FinalCleanCopy.doc.

Decision rationale: According to the 10/04/13 progress report by [REDACTED], the patient presents with neck pain, back pain, and wrist pain presented with decreased range of motion and muscle spasms. The request is for 12 electro acupuncture sessions. Review of the reports do not show any prior acupuncture reports and it is not known whether or not the patient has had acupuncture in the past. MTUS acupuncture guidelines recommend initial trial of 3-6 sessions of acupuncture. The current request for 12 sessions exceeds initial trial of 3-6 sessions recommended by MTUS. Additional treatments are recommended if the initial trial proves to be helpful in terms of functional improvement. Recommendation is for denial. The twelve (12) electro acupuncture sessions are not medically necessary and appropriate.

TWELVE (12) INFRARED LAMP TREATMENTS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - Low Back, Lumbar & Thoracic (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

Decision rationale: According to the 10/04/13 progress report by [REDACTED], the patient presents with neck pain, back pain, and wrist pain presented with decreased range of motion and muscle spasms. The request is for 12 infrared lamp treatments. ACOEM chapter 12 states "Physical modalities such as massage, diathermy, cutaneous laser treatment, ultrasound, transcutaneous electrical neurostimulation (TENS) units, percutaneous electrical nerve stimulation (PENS) units, and biofeedback have no proven efficacy in treating acute low back symptoms." Therefore, the infrared lamp treatments would not be beneficial. While infrared heat lamp can be used in conjunction with acupuncture or therapy, in this case, acupuncture treatments are denied due to 3-6 sessions for trial limitation. Recommendation is for denial. The twelve (12) infrared lamp treatments are not medically necessary and appropriate.

PRESCRIPTION OF PRILOSEC/OMEPRAZOLE 20MG: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms And Cardiovascular Risk..

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms And Cardiovascular Risk. Page(s): 69.

Decision rationale: According to the 10/04/13 progress report by [REDACTED], the patient presents with neck pain, back pain, and wrist pain presented with decreased range of motion and muscle spasms. The request is for Prilosec/Omeprazole 20 mg. There is no documentation that the patient has previously taken this medication. The 10/04/13 report indicates that the patient is currently on Anaprox, Prozac, Tramadol, Vicodin, Flurbiprofen compounded transdermal cream, and Cyclobenzaprine (Gabapentin) transdermal cream. The treater does not document any GI issues or side effects from the use of NSAIDs. There is no profiling of the patient's risk factors. Based on review of the records, I cannot determine that this patient is at any risk of GI side effects from any previous NSAID. MTUS does not recommend routine use of GI prophylaxis without documentation of risk assessment. Recommendation is for denial. The prescription for Prilosec/Omeprazole 20 mg is not medically necessary and appropriate.

PRESCRIPTION OF PROZAC/FLUOXETINE 20MG: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 388.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants For Chronic Pain Page(s): 13-16.

Decision rationale: According to the 10/04/13 progress report by [REDACTED], the patient presents with neck pain, back pain, and wrist pain presented with decreased range of motion and muscle spasms. The request is for Prozac/ Fluoxetine 20 mg. For Anti-depressants, the MTUS page 13-15 states, "Selective Serotonin reuptake inhibitors (SSRIs), a class of antidepressants that inhibit serotonin reuptake without action on noradrenaline, are controversial based on controlled trials. (Finnerup, 2005) (Saarto-Cochrane, 2005) It has been suggested that the main role of SSRIs may be in addressing psychological symptoms associated with chronic pain. (Namaka, 2004). More information is needed regarding the role of SSRIs and pain." No psychological reports were provided for review that may suggest the need for this medication. The treater does not provide documentation of the patient's psychological issues that may benefit from Prozac. No documentation regarding this medication's efficacy has been provided. Recommendation is for denial. The prescription for Prozac/Fluoxetine 20mg is not medically necessary and appropriate.

PRESCRIPTION OF FLURBIPROFEN COMPOUNDED TRANSDERMAL CREAM:

Upheld

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

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

Decision rationale: According to the 10/04/13 progress report by [REDACTED], the patient presents with neck pain, back pain, and wrist pain presented with decreased range of motion and muscle spasms. The request is for Flurbiprofen compounded transdermal cream. MTUS Guidelines provide clear discussion regarding topical compounded creams. It does not support the use of topical NSAIDs for axial, spinal pain, but supports it for peripheral joint arthritis and tendinitis. This patient presents with mostly low back pain for which this topical medication is not indicated. Recommendation is for denial. The prescription of Flurbiprofen Compound Transdermal Cream is not medically necessary and appropriate.

PRESCRIPTION FOR TRAMADOL COMPOUNDED TRANSDERMAL CREAM:

Upheld

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

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

Decision rationale: According to the 10/04/13 progress report by [REDACTED], the patient presents with neck pain, back pain, and wrist pain presented with decreased range of motion and muscle spasms. The request is for Tramadol Compounded Transdermal Cream. MTUS, pages 111-113 states that topical analgesics are "Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support

the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." The guidelines do not include Tramadol for topical compound. There is lack of evidence that topical tramadol can help chronic axial spinal pain. Recommendation is for denial. The prescription for Tramadol Compounded Transdermal Cream is not medically necessary and appropriate.

PRESCRIPTION FOR CYCLOBENZAPRINE AND GABAPENTIN COMPOUNDED TRANSDERMAL CREAM: Upheld

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

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

Decision rationale: According to the 10/04/13 progress report by [REDACTED], the patient presents with neck pain, back pain, and wrist pain presented with decreased range of motion and muscle spasms. The request is for Cyclobenzaprine and Gabapentin compounded transdermal cream. MTUS pages 111-113 state that there is no evidence for use of muscle relaxants as a topical product. Cyclobenzaprine, a muscle relaxant, should not be given as a transdermal cream. Recommendation is for denial. The prescription for Cyclobenzaprine and Gabapentin Compounded Transdermal Cream is not medically necessary and appropriate.