

Case Number:	CM13-0062371		
Date Assigned:	12/30/2013	Date of Injury:	09/03/2012
Decision Date:	04/14/2014	UR Denial Date:	11/29/2013
Priority:	Standard	Application Received:	12/06/2013

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, and is licensed to practice in Texas. 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 30-year-old male who reported an injury on 01/21/1983. The mechanism of injury was not specifically stated. The patient is diagnosed with thoracic myofasciitis, lumbar myofasciitis, and right rib cage pain. The patient was seen by [REDACTED] on 11/15/2013. The patient reported no complaints of pain. The patient was participating in shockwave therapy once per week. Physical examination revealed tenderness to palpation of the lumbar spine, full range of motion, and negative spasms. Treatment recommendations included continuation of shockwave therapy, a Functional Capacity Evaluation, range of motion testing as well as NIOSH testing, continuation of current medication, and a return appointment.

IMR ISSUES, DECISIONS AND RATIONALES

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

UNKNOWN CONTINUED SHOCKWAVE THERAPY:

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 Page(s): 298-300.

Decision rationale: ACOEM Guidelines state physical modalities have no proven efficacy in treating acute low back symptoms. Insufficient evidence exists to determine the effectiveness of these therapies. As per the documentation submitted, the patient has completed an unknown amount of shockwave therapy to date. Documentation of objective functional improvement was not provided. The patient's physical examination only reveals tenderness to palpation of the lumbar spine. The medical necessity for ongoing treatment has not been established. Therefore, the request is not medically necessary and appropriate.

1 RANGE OF MOTION TEST: 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 5 Cornerstones of Disability Prevention and Management Page(s): 89-92.

Decision rationale: The ACOEM Guidelines state a number of functional assessment tools are available, including functional capacity examination and video tapes when reassessing function and functional recovery. As per the documentation submitted, the patient's physical examination only revealed tenderness to palpation. The medical necessity for the requested service has not been established. Therefore, the request is not medically necessary and appropriate.

1 BASELINE AND ONE P&S COMPLETE FUNCTIONAL IMPROVEMENT MEASUREMENT PLUS FUNCTION NIOSH TESTING EVERY 60 DAYS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines, Chapter 7, and the Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 82-92.

Decision rationale: The ACOEM Guidelines state a number of functional assessment tools are available, including functional capacity examination and video tapes when reassessing function and functional recovery. As per the documentation submitted, the patient's physical examination only revealed tenderness to palpation. The medical necessity for the requested service has not been established. Therefore, the request is not medically necessary and appropriate.

30 TRAMADOL 150MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-82.

Decision rationale: The MTUS Chronic Pain Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Baseline pain and functional assessment should be made. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. The patient has continuously utilized this medication. There is no documentation of objective functional improvement. The patient's physical examination only reveals tenderness to palpation. There is no documentation of a failure to respond to nonopioid analgesics. There is also no documentation of a significant musculoskeletal deficit that would require ongoing opioid therapy. Based on the clinical information received, the request is not medically necessary and appropriate.

30 PANTROPRAZOLE 20MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

Decision rationale: The MTUS Chronic Pain Guidelines state proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor, even in addition to a nonselective NSAID. As per the documentation submitted, there is no evidence of cardiovascular disease or increased risk factors for gastrointestinal events. Therefore, the patient does not meet criteria for the requested medication. As such, the request is not medically necessary and appropriate.

3 COMPOUNDED CREAMS: CYCLOBENZAPRINE 10%+GABAPENTIN 10%; FLURBIPROFEN 20%; TRAMADOL 20%: 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: The MTUS Chronic Pain Guidelines state topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety. Cyclobenzaprine is not recommended as there is no peer-reviewed literature to support its use. Gabapentin is also not recommended. The only FDA approved topical NSAID is Diclofenac. Based on the clinical information received and the California MTUS Guidelines, the request is not medically necessary and appropriate.

90 NAPROXEN SODIUM 550MG: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-72.

Decision rationale: The MTUS Chronic Pain Guidelines state NSAIDS are recommend for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. For acute exacerbations of chronic pain, NSAIDS are recommended as a second line treatment option after acetaminophen. As per the documentation submitted, the patient has continuously utilized this medication. There is no documentation of a significant musculoskeletal deficit upon physical examination. Guidelines do not recommend chronic use of this medication. Therefore, the current request cannot be determined as medically appropriate. As such, the request is not medically necessary and appropriate.