

Case Number:	CM13-0070340		
Date Assigned:	01/03/2014	Date of Injury:	05/02/2012
Decision Date:	04/28/2014	UR Denial Date:	11/22/2013
Priority:	Standard	Application Received:	12/24/2013

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 Pain Medicine and is licensed to practice in Texas and Ohio. 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 55-year-old female who reported an injury on 05/02/2012. The mechanism of injury involved a fall. The patient is diagnosed with cervical spine strain rule out radiculopathy, lumbar spine strain rule out radiculopathy, bilateral shoulder impingement syndrome, bilateral lateral epicondylitis, and bilateral carpal tunnel syndrome. The patient was recently seen by [REDACTED] on 12/04/2013. The patient reported bilateral knee pain as well as lower back pain. Physical examination on that date revealed paraspinal muscle tenderness in the cervical spine, spasm in the cervical spine, tenderness to palpation of bilateral elbows, tenderness in bilateral wrist joint lines, reduced grip strength bilaterally, tenderness in the thoracolumbar spine, spasm in the thoracolumbar spine, and well-healed scar over bilateral knees. The patient was given a refill of Norco, Carisoprodol, and a new prescription for Voltaren Gel. Treatment recommendations also included physical therapy 3 times per week for 4 weeks as well as a follow-up with a psychologist and pain management specialist.

IMR ISSUES, DECISIONS AND RATIONALES

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

KETOPROFEN 75MG DAILY: 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 Page(s): 67-72.

Decision rationale: The California MTUS Chronic Pain Medical Treatment Guidelines state NSAIDS are recommended 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 after acetaminophen. There is no evidence of long term effectiveness for pain or function. The current request does not specify a quantity. Therefore, the current request cannot be supported. The request for Ketoprofen 75 mg daily is not medically necessary and appropriate.

CARISOPRODOL 350MG TWICE PER DAY: 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 Page(s): 63-66 and 124.

Decision rationale: The California MTUS Chronic Pain Medical Treatment Guidelines state muscle relaxants are recommended as non-sedating second line options for short term treatment of acute exacerbations. Soma should not be used for longer than 2 to 3 weeks. There was no specific quantity listed in the current request. Therefore, the request cannot be supported. The request for Carisoprodol 350 mg twice per day is not medically necessary and appropriate.

HYDROCODONE APAP 5-325MG TWICE PER DAY: 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 Page(s): 74-82.

Decision rationale: The California MTUS Chronic Pain Medical Treatment Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Baseline pain and functional assessments should be made. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. There is no specific quantity listed in the current request. The request for Hydrocodone APAP 5-325 mg twice per day is not medically necessary and appropriate.

MEDROX PAIN RELIEF OINTMENT TWICE PER DAY: 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 Treatment Guidelines Page(s): 111-113.

Decision rationale: The California MTUS Chronic Pain Medical Treatment Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. There is no specific quantity listed in the current request. Therefore, the request cannot be supported. The request for Medrox pain relief ointment twice per day is not medically necessary and appropriate.

ZOLPIDEM TARTRATE 10MG AT BEDTIME: 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) Chronic Pain Chapter, Insomnia Treatment

Decision rationale: The Official Disability Guidelines (ODG) state insomnia treatment is recommended based on etiology. Ambien is indicated for the short term treatment of insomnia with difficulty of sleep onset for 7 to 10 days. There is no specific quantity listed in the current request. The request for Zolpidem 10 mg at bedtime is not medically necessary and appropriate.

PHYSICAL THERAPY THREE (3) TIMES PER WEEK FOR FOUR (4) 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 Chronic Pain Treatment Guidelines Treatment Guidelines Page(s): 98-99.

Decision rationale: The California MTUS Guidelines state active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Guidelines allow for a fading of treatment frequency plus active self-directed home physical medicine. Treatment for myalgia and myositis unspecified includes 9 to 10 visits over 8 weeks. Treatment for neuralgia, neuritis and radiculitis unspecified includes 8 to 10 visits over 4 weeks. Documentation of this patient's participation in a previous course of physical therapy was not provided. Additionally, the current request for 12 sessions of physical therapy exceeds guideline recommendations. The request for physical therapy three times per week for four weeks for the cervical spine is not medically necessary and appropriate.

PHYSICAL THERAPY THREE (3) TIMES PER WEEK FOR FOUR (4) WEEKS FOR THE LUMBAR SPINE: 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 Treatment Guidelines Page(s): 98-99.

Decision rationale: The California MTUS Guidelines state active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Guidelines allow for a fading of treatment frequency plus active self-directed home physical medicine. Treatment for myalgia and myositis unspecified includes 9 to 10 visits over 8 weeks. Treatment for neuralgia, neuritis and radiculitis unspecified includes 8 to 10 visits over 4 weeks. Documentation of this patient's participation in a previous course of physical therapy was not provided. Additionally, the current request for 12 sessions of physical therapy exceeds guideline recommendations. The request for physical therapy three times a week for four weeks for the lumbar spine is not medically necessary and appropriate.

PHYSICAL THERAPY THREE (3) TIMES PER WEEK FOR FOUR (4) WEEKS FOR THE BILATERAL EPICONDYLITIS: 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 Treatment Guidelines Page(s): 98-99.

Decision rationale: The California MTUS Guidelines state active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Guidelines allow for a fading of treatment frequency plus active self-directed home physical medicine. Treatment for myalgia and myositis unspecified includes 9 to 10 visits over 8 weeks. Treatment for neuralgia, neuritis and radiculitis unspecified includes 8 to 10 visits over 4 weeks. Documentation of this patient's participation in a previous course of physical therapy was not provided. Additionally, the current request for 12 sessions of physical therapy exceeds guideline recommendations. The request for physical therapy three times a week for four weeks for the bilateral epicondylitis is not medically necessary and appropriate.

PHYSICAL THERAPY THREE (3) TIMES PER WEEK FOR FOUR (4) WEEKS FOR THE BILATERAL CTS (CARPAL TUNNEL SYNDROME): 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 Treatment Guidelines Page(s): 98-99.

Decision rationale: California MTUS Guidelines state active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Guidelines allow for a fading of treatment frequency plus active self-directed home physical medicine. Treatment for myalgia and myositis unspecified includes 9 to 10 visits over 8 weeks. Treatment for neuralgia, neuritis and radiculitis unspecified includes 8 to 10 visits over 4 weeks. Documentation of this patient's participation in a previous course of physical therapy was not provided. Additionally, the current request for 12 sessions of physical therapy exceeds guideline recommendations. The request for physical therapy three times a week for four weeks for the bilateral carpal tunnel syndrome (CTS) is not medically necessary and appropriate.

CPAP (CONTINUOUS POSITIVE AIRWAY PRESSURE) MACHINE: 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 www.nlm.nih.gov. U.S. National Library of Medicine. U.S. Department of Health and Human Services National Institutes of Health. Updated: 26 February 2014

Decision rationale: CPAP stands for continuous positive airway pressure. CPAP delivers slightly pressurized air during the breathing cycle and keeps the windpipe open during sleep to prevent episodes of blocked breathing in patients with obstructive sleep apnea and other breathing problems. Although it is noted in the documentation provided for review that the patient's CPAP machine was requested based on the severity of the sleep apnea indicated on the patient's sleep study, the patient's sleep study was not provided for review. The patient does not maintain a diagnosis of obstructive sleep apnea. Without a previous sleep study report indicating that treatment with CPAP is medically necessary, the request cannot be supported. The request for a CPAP machine is not medically necessary and appropriate.