

Case Number:	CM13-0071422		
Date Assigned:	01/08/2014	Date of Injury:	10/17/2005
Decision Date:	06/05/2014	UR Denial Date:	12/19/2013
Priority:	Standard	Application Received:	12/27/2013

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 injured worker is a 53 year old female with an injury reported on 10/17/2005. The mechanism of injury was not provided in clinical documentation. The clinical note dated 11/25/2013 reported the injured worker complained of left shoulder radiating to mid scapular area. Per the examination the dorsal hand veins were emptying slowly as indicated by the angle for right shoulder for emptying being 140 degrees and the left at 150 degrees; the normal range was noted at 90 degrees. It was also noted that the injured worker experienced post-traumatic headaches. The injured worker's diagnoses included post traumatic occipital headache (migraine type), cervical radiculopathy with degenerative cervical spine disease. The request for authorization was submitted on 12/19/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 PRESCRIPTION FOR MIGRANAL NASAL SPRAY: Upheld

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

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

Decision rationale: The injured worker's diagnoses included post traumatic occipital headache (migraine type), cervical radiculopathy with degenerative cervical spine disease. The Official Disability Guidelines recommend triptans for migraine sufferers. There is no clinical evidence that the injured worker previously utilized an oral medication for migraines. It was unclear why the injured worker would require a nasal spray as opposed to an oral medication for migraines. Therefore, the request for 1 prescription for migranal nasal spray is not medically necessary and appropriate.

1 PRESCRIPTION FOR GABAPENTIN: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 19,49.

Decision rationale: The injured worker complained of left shoulder radiating to mid scapular area. According to the MTUS Chronic Pain Guidelines, Gabapentin is an anti-epilepsy drug (AEDs - also referred to as anti-convulsant), which has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. There is a lack of clinical evidence pertaining to the injured worker's utilization of Gabapentin including the effectiveness of the medication for pain and discomfort, the longevity of medication use, and the dosage of the Gabapentin. Furthermore, the provider did not specify the amount of Gabapentin being requested. Therefore, the request is not medically necessary and appropriate.

1 PRESCRIPTION FOR MEXILETINE: 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): 37-38.

Decision rationale: The injured worker complained of left shoulder radiating to mid scapular area. The injured worker was also noted had experienced post-traumatic headaches. According to the MTUS Chronic Pain Guidelines most medications have limited effectiveness for complex regional pain syndrome. The MTUS Chronic Pain Guidelines note mexiletine, lidocaine patches and capsaicin are used for complex regional pain syndrome but efficacy is not convincing. There is a lack of clinical information provided on the injured worker's previous use of mexiletine, including the medication effectiveness, oral capsule versus extended release. Furthermore, the provider did not specify the amount being requested. Therefore, the request for 1 prescription for mexiletine is not medically necessary and appropriate.

1 PRESCRIPTION FOR PRODRIN: Upheld

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

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

Decision rationale: The injured worker experienced post-traumatic headaches. The injured worker's diagnoses included post traumatic occipital headache (migraine type). Prodrin is a combination medicine which consists of acetaminophen, caffeine, and isometheptene mucate. The Official Disability Guidelines recommend triptans for migraine sufferers. was lack of documentation indicating the severity of the injured workers migraine headaches. It was unclear if the injured worker previously attempted treatment with a triptan medication. Furthermore, the provider did not specify the amount of medication being requested. Therefore, the request for 1 prescription for prodrin is not medically necessary and appropriate.

1 BODY BUOY: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg, Durable Medical Equipment (DME).

Decision rationale: The injured worker experienced post-traumatic headaches. The injured worker's diagnoses included post traumatic occipital headache (migraine type), cervical radiculopathy with degenerative cervical spine disease. The injured worker was noted utilizing a back buoy with considerable benefit. According to the Official Disability Guidelines durable medical equipment (DME) is recommended generally if there is a medical need. Durable medical equipment (DME) is defined as equipment which can withstand repeated use, i.e., could normally be rented, and used by successive patients, is primarily and customarily used to serve a medical purpose, generally is not useful to a person in the absence of illness or injury; and is appropriate for use in a patient's home. It was also documented that the injured worker rode home without the back buoy for a 1.5 hour car ride, before experiencing some discomfort. There is a lack of clinical evidence within the medical records provided for review for a rationale of a specific need for a body buoy. Additionally, a body buoy would be beneficial in the absence of illness of injury. Therefore, the request for 1 body buoy is not medically necessary and appropriate

6 PHYSICAL THERAPY 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 based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES PHYSICAL MEDICINE, , 98

Decision rationale: The injured worker complained of left shoulder pain radiating to mid scapular area. The injured worker's diagnoses included cervical radiculopathy with degenerative cervical spine disease. According to the MTUS Chronic Pain Guidelines, 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. Per the clinical information provided, the provider suggested physical therapy was not currently possible due to pain level and in the absence of a body buoy. The provider did not include an adequate and complete assessment of the injured worker's current condition. It was unclear if the injured worker had significant functional deficits. Therefore, the request for 6 physical therapy sessions is not medically necessary and appropriate.

1 PRESCRIPTION OF ZOMIG NASAL SPRAY: Upheld

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

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

Decision rationale: The injured worker's diagnoses included post traumatic occipital headache (migraine type), cervical radiculopathy with degenerative cervical spine disease. The Official Disability Guidelines recommend triptans for migraine sufferers. There is no clinical evidence that the injured worker previously utilized an oral medication for migraines. It was unclear why the injured worker would require a nasal spray as opposed to an oral medication for migraines. Therefore, the request for 1 prescription of zomig nasal spray is not medically necessary and appropriate.