MAXIMUS Federal Services

Case Number:	CM14-0103081		
Date Assigned:	07/30/2014	Date of Injury:	06/07/2013
Decision Date:	09/11/2014	UR Denial Date:	06/04/2014
Priority:	Standard	Application Received:	07/03/2014

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 and Rehabilitation and is licensed to practice in Nevada. 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 records presented for review indicate that this 55 year-old individual was reportedly injured on June 7, 2013. The mechanism of injury is noted as a gradual onset of symptoms while sitting at the desk. The most recent progress note, dated May 16, 2014, indicates that there are ongoing complaints of neck, back and right upper extremity pain. The physical examination demonstrated normal blood pressure, tenderness to palpation to the posterior aspect of the right shoulder and a cervical paraspinous musculature. Diagnostic imaging studies objectified and ordinary disease of life impingement syndrome of the right shoulder. Previous treatment includes plain films, enhanced imaging studies, elected diagnostic studies, multiple medications, physical therapy, and a wrist brace. A request had been made for multiple medications and was not certified in the pre-authorization process on June 4, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol ER 150mg, #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 82, 113.

Decision rationale: When noting the date of injury, the mechanism of injury, the multiple complaints and the lack of any specific objective pathology to place complaints there is little clinical indication presented for the continued use of opioid analgesics. This is a 2nd line treatment and there is no noted efficacy. The pain complaints remain unchanged, the physical examination remains unchanged, and there is nothing in the narrative suggesting the need for such an intervention. Therefore, the request of Tramadol ER 150mg, #30 is not medically necessary and appropriate.

Naproxen 550mg, #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 66 & 73.

Decision rationale: This is a nonspecific non-steroidal anti-inflammatory medication used to treat the signs and symptoms of osteoarthritis. There is also an indication for chronic low back pain; however when noting the last several physical examination assessments, there is no objective signs that the inflammatory processes have responded to this medication. There are ongoing pain complaints and inflammation in the cervical facet joints, ongoing lateral epicondylitis and no indicator that any of these have improved. Therefore, the efficacy of this medication has not been established in the progress of presented for review. Consequently, the request of Naproxen 550mg, #60 is not medically necessary and appropriate.

Protonix 20mg, #60: 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.

Decision rationale: The progress notes indicate complaints of pain in the neck, right shoulder, right elbow, low back and yet there are no gastrointestinal complaints. This individual has been taking non-steroidal medication and the indication for protein pump inhibitors is as a protectorate against those individuals who have some distress associated medication. Noting that the efficacy of this medication is longer established, and no longer any clinical indication for a medication to address gastrointestinal distress, therefore, the request of Protonix 20mg #60 is not medically necessary and appropriate.

Gabapentin 600mg, #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 16-20.

Decision rationale: This medication is clinically indicated for the treatment of a painful diabetic neuropathy or a post-herpetic neuralgia. Neither these maladies is noted to exist. An off label use of this medication is to treat neuropathic pain lesion. There is no objectification of a specific neuropathic pain lesion or that this medication would address such a lesion. Given that there is no noted improvement in the overall symptomology there is no objectified efficacy for the continued use of this medication. Therefore, the request of Gabapentin 600mg, #90 is not medically necessary and appropriate.

Chiropractic visits: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy and manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-59.

Decision rationale: As noted in the guidelines, chiropractic care can be supported for muscle skeletal condition. In that the mechanism of injury support that the cause ideology is muscle skeletal in nature and it is not clear chiropractic care has been attempted. There is a clinical indication establishing medical necessity. However, there needs to be documentation of improvement after the 1st several weeks prior to any additional chiropractic visits. Therefore, the request of Chiropractic visits is medically necessary and appropriate.

In home TENS unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 113 - 116.

Decision rationale: As outlined in the MTUS, the support of this type of device is only limited to certain clinical situations. Furthermore a trial of this device needs to be objectified as demonstrated some efficacy. Therefore, the request of in home TENS (Transcutaneous Electric Nerve Stimulation) unit is not medically necessary and appropriate.

EMG of the upper extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

Decision rationale: As noted in the ACOEM guidelines, such studies are indicated when there is subtle focal neurologic dysfunction identified. When noting the physical examination reported, no such dysfunction has been identified. Furthermore, there is no enhanced imaging studies demonstrating a nerve root compromise there was just need of a radiculopathy. As such, the request of EMG (Electromyography) of the upper extremity is not medically necessary and appropriate.

MRI of the right wrist: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

Decision rationale: As noted in the guidelines, such studies are not recommended for acute, sub acute or chronic distal upper extremity complaints. Plain films are supported. Furthermore, the physical examination notes changes consistent with a joint inflammation. As such, the request of MRI of the right wrist is not medically necessary and appropriate.