

Case Number:	CM14-0106987		
Date Assigned:	08/01/2014	Date of Injury:	02/05/2007
Decision Date:	10/10/2014	UR Denial Date:	06/19/2014
Priority:	Standard	Application Received:	07/10/2014

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 52 year-old individual was reportedly injured on March 5, 2007. The mechanism of injury is noted as a lifting type event and a low back injury was noted. The most recent progress note, dated July 25, 2014, indicates that there are ongoing complaints of sharp stabbing neck pain rated at 8/10. The physical examination demonstrated a well-developed, well-nourished individual who is in no acute distress. A decrease in cervical spine range of motion is reported, as well as a positive cervical distraction from a compression and a shoulder depression test. There is a decrease in the bilateral shoulder range of motion and tenderness over the acromioclavicular joint. There are sensory changes noted in the C6 and C7 dermatomes. Motor function is also decreased throughout both upper extremities. A decrease in lumbar spine range of motion is noted combined with tenderness to palpation and paraspinal muscle guarding. Diagnostic imaging studies were not reported in this narrative. Previous treatment includes multiple medications, physical therapy, and pain management interventions. A request had been made for multiple medications and was not certified in the pre-authorization process on June 19, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Unknown shockwave therapy sessions for the cervical spine: 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 and Thoracic (Acute and Chronic)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), neck chapter, updated September, 2014

Decision rationale: MTUS/ACOEM practice guidelines support Extracorporeal Shock Wave Therapy (ESWT) for treatment of calcific rotator cuff tendinitis of the shoulder alone. The MTUS does not address shockwave therapy for the cervical spine. The parameters noted in the ODG were employed. As noted in the ODG, this is not recommended for anything other than calcific tendinitis which is not a diagnosis for this injured worker. As such, there is no medical necessity for this intervention.

Unknown shockwave therapy sessions for the lumbar spine: 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 and Thoracic (Acute and Chronic)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), low back chapter, updated September, 2014

Decision rationale: MTUS/ACOEM practice guidelines support Extracorporeal Shock Wave Therapy (ESWT) for treatment of calcific rotator cuff tendinitis of the shoulder alone. The MTUS does not address shockwave therapy for the lumbar spine. The parameters noted in the ODG were employed. As noted in the ODG, this is not recommended for anything other than calcific tendinitis which is not a condition the injured worker has been diagnosed with. As such, there is no medical necessity for this intervention.

Sleep study: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), pain chapter, updated October, 2014

Decision rationale: The MTUS or ACOEM guidelines do not address this study. As outlined in the ODG, this assessment is recommended for a combination of indications. Based on the clinical records presented for review, there is no objectification that each of the following criterion are met: (1) Excessive daytime somnolence; (2) Cataplexy (muscular weakness usually brought on by excitement or emotion, virtually unique to narcolepsy); (3) Morning headache

(other causes have been ruled out); (4) Intellectual deterioration (sudden, without suspicion of organic dementia); (5) Personality change (not secondary to medication, cerebral mass, or known psychiatric problems); (6) Sleep-related breathing disorder or periodic limb movement disorder is suspected; and (7) Insomnia complaint for at least six months (at least four nights of the week), unresponsive to behavior intervention and sedative/sleep-promoting medications and psychiatric etiology has been excluded. Therefore, this is not medically necessary.

Unknown prescription of Deprizine: 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): 67-68.

Decision rationale: This medication is a compound oral suspension preparation of a protein pump inhibitor. This medication is indicated for the treatment of gastroesophageal reflux disease or as a protectorate for non-steroidal medications. When noting the date of injury, the injury sustained, the current physical examination presented for review as well as the specific notation that there were no gastrointestinal complaints or findings on physical examination, there simply any clinical indication presented for the medical necessity of this operation. Therefore, this is not clinically indicated or medically necessary.

Unknown prescription of Dicopanol: 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): 65.

Decision rationale: Diphenhydramine (Dicopanol) is an oral suspension compounded medication to treat allergic reactions, motion sickness, and symptoms of Parkinson's disease. This medication is basically an antihistamine; the parameters for antihistamines are not noted to be applicable based on the medical records presented for review. As such, the medical necessity has not been established.

Unknown prescription of Fanatrex: 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): 16-18.

Decision rationale: This is an oral suspension compounded medication which is basically Gabapentin. This medication is primarily indicated to treat seizures, and off label use has been noted to address neuropathic pain lesion. The progress notes did not demonstrate any efficacy or utility with the continued use of this medication. Therefore, the medical necessity of this preparation has not been established.

Unknown prescription of Synapryn: 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): 82, 113.

Decision rationale: MTUS treatment guidelines support the use of Tramadol (Ultram) for short-term treatment of moderate to severe pain after there has been evidence of failure of a first-line option and documentation of improvement in pain and function with the medication. Given the claimant's date of injury, the current clinical presentation, current diagnosis, and the lack of any objectification of efficacy or utility with the utilization of this preparation, the guidelines do not support the use of this medication. As such, this request is not considered medically necessary.

Unknown prescription of Tabradol: 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 Muscle relaxants Page(s): 41, 64.

Decision rationale: MTUS Guidelines support the use of skeletal muscle relaxants for the short-term treatment of pain, but advice against long-term use. Given the claimant's date of injury, clinical presentation, that there is no identified or objectified improvement in the overall symptomology or findings on physical examination, the guidelines do not support this request for chronic pain. As such, the request is not medically necessary.

Unknown prescription of Cyclobenzaprine: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 41, 64.

Decision rationale: MTUS Guidelines support the use of skeletal muscle relaxants for the short-term treatment of pain, but advice against long-term use. Given the claimant's date of injury and

clinical presentation, the guidelines do not support this request for chronic pain. As such, the request is not medically necessary.

One (1) prescription of Ketoprofen Cream: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-112.

Decision rationale: MTUS guidelines support topical NSAIDs for the short-term treatment of acute pain, for short-term use for individuals unable to tolerate oral administration, or when oral administration is contraindicated. The record provides no documentation that the claimant has or is taking oral anti-inflammatory medications. When noting that there is no documentation of intolerance or contraindication to first-line therapies, there is no clinical indication for the use of this medication with the diagnoses noted. Furthermore, the records do not reflect that there is any objectified efficacy or utility in terms of decreased symptomology or increased functionality as a result of the use of this medication. Therefore, this request is not medically necessary.

Unknown prescription of Terocin Patches: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 105, 112.

Decision rationale: Terocin is a topical analgesic containing Lidocaine and Menthol. MTUS guidelines support topical Lidocaine as a secondary option for neuropathic pain after a trial of an antiepileptic drug or anti-depressants have failed. There is no evidence-based recommendation or support for Menthol. MTUS guidelines state that topical analgesics are "largely experimental" and that "any compound product that contains at least one drug (or drug class) that is not recommended is not recommended". As such, this request is considered not medically necessary.

Consultation with a pain management specialist regarding epidural steroid injections: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 7, page 127

Decision rationale: As noted in the MTUS, a consultation is to be obtained if the diagnosis is uncertain or extremely complex. The diagnosis has been well-established and the treatment plan is well-established, as such is no clear clinical indication for a consultation. Therefore, based on the clinical information presented in the progress notes reviewed, this is not medically necessary.