

Case Number:	CM14-0115387		
Date Assigned:	08/06/2014	Date of Injury:	05/06/2010
Decision Date:	09/24/2014	UR Denial Date:	07/07/2014
Priority:	Standard	Application Received:	07/23/2014

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 Occupational Medicine and is licensed to practice in California. 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 46-year-old female who was injured on 05/06/2010. The mechanism of injury is unknown. Prior treatment history has included physical therapy. Prior medication history included Tylenol #3, omeprazole, Flexeril 10 mg. The patient underwent anterior cervical discectomy and fusion at C5-C6 on 12/11/2013. Progress report dated 07/25/2014 indicates the patient presented with constant severe postoperative cervical spine pain, rated as 8/10 with associated soreness in the bilateral shoulders. She also complained of bilateral shoulder pain rated as 8/10 with limited range of motion, tightness and tenderness. She notes that her bilateral shoulder pain is aggravated with overhead activities. Objective findings on exam revealed tenderness to palpation of the right shoulder. Range of motion revealed forward flexion at 130/80 degrees, extension at 30/50 degrees; abduction at 110/180; adduction at 30/50 degrees; internal rotation at 45/90 degrees, and external rotation at 35/90. Diagnoses are right shoulder impingement syndrome, bilateral carpal tunnel syndrome. The patient is recommended for physical therapy and MRI of right shoulder to rule out internal derangement. Prior utilization review dated 07/07/2014 states the request for Physical Therapy 2 times a week for 4 weeks for Cervical Spine and Bilateral Shoulders is denied as there is a lack documentation to support the request; Prilosec 20mg #30 is denied as there is no documented evidence to support the request; Flexeril 10mg #90 is denied as long term use of muscle relaxants are not supported by guidelines; Tylenol #3 300/30mg #60 is denied as medical necessity has not been established; Medrox Patches #30 is denied as it is not recommended for topical application; Compounding Cream is denied as any compounded product that contains at least one drug or drug class that is not recommended is not recommended; Pro Wrist Support for the Right Wrist is denied as there is a lack of documented evidence to support the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 2 times a week for 4 weeks for Cervical Spine and Bilateral Shoulders:
Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99, Postsurgical Treatment Guidelines.

Decision rationale: According to MTUS post-surgical treatment guidelines, 24 visits of physical therapy over 16 weeks within a 6 month treatment period are recommended after cervical fusion. MTUS chronic pain guidelines recommend up to 8 to 10 visits of physical therapy over 8 weeks for acute exacerbations of chronic pain. In this case, a request is made for an additional 8 visits of physical therapy for a 46-year-old female status post cervical fusion at C5-6 on 12/11/13, L shoulder impingement status post decompression surgery and R shoulder impingement. However, history and examination findings do not demonstrate significant functional improvement from past physical therapy. The number of prior physical therapy visits is not clear from provided records. The request is made outside the treatment period of 6 months for cervical fusion. Finally, there does not appear to have been an interval reinjury or acute exacerbation. Medical necessity is not established.

Prilosec 20mg #30: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Proton Pump Inhibitors.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69. Decision based on Non-MTUS Citation www.pdr.net.

Decision rationale: According to MTUS guidelines, PPI's such as Prilosec are recommended for patients taking NSAIDs at moderate to high risk of gastrointestinal events. According to a search on www.pdr.net, Prilosec is indicated for frequent heartburn. In this case the patient has documented GERD and is prescribed Diclofenac. Medical necessity is established.

Flexeril 10mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-66.

Decision rationale: According to MTUS guidelines, muscle relaxants are recommended for short-term treatment of acute exacerbations of low back pain. However, in this case Flexeril is prescribed on a long-term basis without evident functional improvement. History and examination findings do not support an exception to guideline recommendations for short-term use. Medical necessity is not established.

Tylenol #3 300/30mg #60: 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): 74-96.

Decision rationale: According to MTUS guidelines, opioids are recommended for moderate to severe pain. Efficacy of long-term opioid for chronic, non-malignant pain is not clearly established. In this case a request is made for Tylenol #3, which the patient is prescribed on a long-term basis. However, history and examination findings do not demonstrate clinically significant functional improvement, including reduction in dependency on medical care, or pain reduction due to use of Tylenol #3. Medical necessity of ongoing use is not established.

Medrox Patches #30: 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 Topical Analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Topical Analgesics <http://dailymed.nlm.nih.gov/dailymed/archives/fdaDrugInfo.cfm?archiveid=55285>.

Decision rationale: This is a request for Medrox patches, which appear to contain capsaicin, menthol and methyl salicylate. According to MTUS guidelines, topical NSAIDs may be indicated for short-term, 4-12 weeks, treatment of osteoarthritis or tendinitis. However, in this case, osteoarthritis or tendinitis is not documented, and treatment appears to be long-term. History and examination findings do not support an exception to guideline recommendations. Medical necessity is not established.

Compounding Cream: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113. Decision based on Non-MTUS Citation <http://ipscompounding.com/pain-cream/>.

Decision rationale: This is a request for "compounding cream." Record review suggests this cream contains gabapentin, Flexeril, ketamine, ketoprofen among other ingredients. However, according to MTUS guidelines, ketoprofen, Flexeril and gabapentin are not recommended for topical application. Topical ketamine is under study. Medical necessity is not established.

Pro Wrist Support for the Right Wrist: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Carpel Tunnel Syndrome, Splinting <http://www.breg.com/products/elbow-wrist-bracing/wrist/wrist-pro>.

Decision rationale: According to MTUS guidelines, wrist splinting is recommended for acute, subacute and chronic carpal tunnel syndrome. ODG guidelines recommend neutral wrist splints for the treatment of carpal tunnel syndrome. In this case a request is made for a wrist support for the right wrist. The patient has documented bilateral carpal tunnel syndrome. Medical necessity is established.