

Case Number:	CM14-0118479		
Date Assigned:	08/06/2014	Date of Injury:	10/27/2009
Decision Date:	09/23/2014	UR Denial Date:	07/03/2014
Priority:	Standard	Application Received:	07/28/2014

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 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 injured worker is a 56-year-old male who reported an injury on 10/27/2009 who sustained injury to his neck and back while lifting a large mattress weighing over 100 pounds up a flight of stairs. The injured worker's treatment history included physical therapy, medications, MRI studies, EMG/NCV studies, X-rays, and chiropractic treatment. He was evaluated on 06/11/2014 and, the injured worker complained of an exacerbation of symptoms in the neck, right shoulder, thoracic spine, low back, right hip, right knee, right ankle, and right foot. He also complained of moderate headaches, depression, anxiety, and difficulty sleeping. He appeared to be in moderate distress and ambulated with the use of crutches. Objective findings included decreased range of motion in cervical, thoracic, and lumbar spine, positive impingement sign with tenderness in the rotator cuff, lateral tenderness in the right elbow, tenderness and spasm elicited with palpation of the upper, mid, and lower paraspinal muscles in the thoracic area with trigger points, positive nerve root tension sign bilaterally, decreased sensation over the right anterolateral and lateral thigh, anterior knee, medial and posterior leg, decreased motor strength in the right upper and lower extremities, and tenderness and muscle spasm in the paralumbar musculature bilaterally. In the documentation, the provider the injured worker was able to return to work with restriction; however, he was not working. Medications included ibuprofen, Tylenol 3, and cyclobenzaprine. Diagnoses included head pain, cervical sprain/strain with radiculitis, cervical spine discogenic disease, thoracic sprain/strain, thoracic spine myofascial pain syndrome, lumbar sprain/strain, lumbar radiculopathy, lumbar spine disc protrusions, right shoulder sprain/strain, right shoulder tendonitis, right elbow sprain/strain, right elbow lateral epicondylitis, right wrist sprain/strain, right knee sprain/strain, right knee meniscal tear, right ankle sprain/strain. The authorization dated 06/11/2014 was for 12 extracorporeal shockwave therapy treatments, 1 power uplift seat, and Tylenol 3 and Menthoderm gel. However, the rationale was not submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

12 EXTRACORPOREAL SHOCKWAVE THERAPY TREATMENTS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Extracorporeal shock wave (ESWT) Knee & Leg.

Decision rationale: The requested is not medically necessary. According to the Official Disability Guidelines (ODG) extracorporeal shock wave for the knee is under study for patellar tendinopathy and for long-bone hypertrophic non-unions. In the first study of this therapy for management of chronic patellar tendinopathy, extracorporeal shockwave therapy seemed to be safer and more effective, with lower recurrence rates, than conventional conservative treatments, according to results of a recent small, randomized controlled trial. New research suggests that extracorporeal shock-wave therapy (ESWT) is a viable alternative to surgery for long-bone hypertrophic non-unions. However, the findings need to be verified, and different treatment protocols as well as treatment parameters should be investigated, including the number of shock waves used, the energy levels applied and the frequency of application. New data presented at the American College of Sports Medicine Meeting suggest that extracorporeal shockwave therapy (ESWT) is ineffective for treating patellar tendinopathy, compared to the current standard of care emphasizing multimodal physical therapy focused on muscle retraining, joint mobilization, and patellar taping. The injured worker diagnoses stated he was being treated for right knee strain/sprain. Additionally the request failed to indicate location where extracorporeal shock wave therapy is required for the injured worker. As such, the request for 12 extracorporeal shockwave therapy treatments is not medically necessary.

1 POWER UPLIFT SEAT: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES, KNEE AND LEG CHAPTER.

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 Equipment.

Decision rationale: The requested is not medically necessary. According to the Official Disability Guidelines (ODG) state that Durable medical equipment the home. Medical conditions that result in physical limitations for patients may require patient education and modifications to the home environment for prevention of injury, but environmental modifications are considered not primarily medical in nature. Certain DME toilet items (commodes, bed pans, etc.) are

medically necessary if the patient is bed- or room-confined, and devices such as raised toilet seats, commode chairs, sitz baths and portable whirlpools may be medically necessary when prescribed as part of a medical treatment plan for injury, infection, or conditions that result in physical limitations. Many assistive devices, such as electric garage door openers, microwave ovens, and golf carts, were designed for the fully mobile, independent adult, and Medicare does not cover most of these items. The provider failed to indicate the rationale why he was requesting for 1 power uplift seat for the injured worker. As such, the request for a 1 power uplift seat is not medically necessary.

TYLENOL 3 # 60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Codeine Page(s): 35.

Decision rationale: The requested is not medically necessary. Per California Medical Treatment Utilization Schedule (MTUS) Guidelines, state Tylenol 3 is recommended as an option for mild to moderate pain, as indicated below. Codeine is a schedule C-II controlled substance. It is similar to morphine. 60 mg of codeine is similar in potency to 600 mg of acetaminophen. It is widely used as a cough suppressant. It is used as a single agent or in combination with acetaminophen (Tylenol with Codeine) and other products for treatment of mild to moderate pain. Adverse effects: Common effects include CNS depression and hypotension. Drowsiness and constipation occur in > 10% of cases. Codeine should be used with caution in patients with a history of drug abuse. Tolerance as well as psychological and physical dependence may occur. Abrupt discontinuation after prolonged use may result in withdrawal. The documentation submitted indicated the injured worker had conservative care such as physical therapy, however the outcome measurements or long-term functional goals were not submitted for this review. The provider failed to include functional improvement after the injured worker takes prescribed medication. The request submitted failed to include duration and frequency of prescribed medication. The request for Tylenol 3 # 60 is not medically necessary.

MENTHODERM GEL: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: The requested is not medically necessary. The California Medical Treatment Utilization Schedule (MTUS) guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The guidelines also state that any compounded product contains at least one drug (or drug class) that is not recommended. Methoderm gel contains at least one or more drug class. The guidelines

state that there are no other commercially approved topical formulation of lidocaine (whether creams, lotions, or gels) that are indicated for neuropathic pain other than Lidoderm. The proposed gel contains methyl salicylate and menthol. Furthermore, there was no documentation provided on conservative care measures such as physical therapy or pain management. In addition, there was no documentation provided on frequency or location where the Mentoderm gel would be applied and unspecified quantity of the ointment was not provided. As such, the request for Mentoderm gel is not medically necessary.