MAXIMUS Federal Services

Case Number:	CM14-0123146		
Date Assigned:	08/08/2014	Date of Injury:	11/08/2013
Decision Date:	09/15/2014	UR Denial Date:	07/30/2014
Priority:	Standard	Application Received:	08/05/2014

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 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 injured worker is a 55-year-old female with a reported date of injury on 11/08/2013; the mechanism of injury was repetitive motion. The injured worker was diagnosed with cervicalgia, cervical radiculopathy, carpal tunnel syndrome, De Quervain's tenosynovitis, shoulder impingement, left knee meniscus injury, and insomnia. Prior treatments included medications, a knee brace, Depo-Medrol injections, and physical therapy. Diagnostic studies included an MRI of the left knee, an MRI of the cervical spine, x-rays of the left knee, x-rays of the cervical spine, an MRI of the left shoulder, an MRI of the right shoulder, an MRI of the right ankle, x-rays of the left hand, x-rays of the left elbow, x-rays of the bilateral knees, and an MRI of the left knee. The clinical note dated 07/16/2014 noted the injured worker reported bilateral shoulder pain, right greater than left. The injured worker reported increased right shoulder pain with reaching behind and down. The physician indicated Voltaren gel helped the injured worker's pain. There was tenderness to palpation noted over the cervical paraspinal musculature, upper trapezius, and scapular border. There was tenderness to palpation over the bicipital tendon, and anterior and posterior translation was noted to be positive. The injured worker's medication regimen included Voltaren gel 1%, Halcion 0.125 mg, and Voltaren XR 100 mg. The physician's treatment plan included recommendations for the injured worker to continue their medication regimen, as well as recommendations for prolotherapy injections to the bilateral shoulders, and continuation of the home exercise program, heat, and ice. The physician's rationale for the request was not indicated within the medical records. The Request for Authorization form was dated 07/16/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prolotherapy injection bilateral shoulders: Upheld

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

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

Decision rationale: The Official Disability Guidelines state prolotherapy is not recommended as there are no published studies for use for the rotator cuff or in the shoulder. Per the provided documentation the injured worker had pain to the bilateral shoulders, right greater than left, with tenderness upon palpation over the cervical paraspinal musculature, upper trapezius, scapular border, and over the bicipital tendon. There is a lack of documentation indicating the injured worker has significant objective deficits for which injections would be needed. The requesting physician's rationale for the request was not indicated within the documentation. Additionally, the guidelines do not recommend the use of prolotherapy. As such, the request for Prolotherapy injection bilateral shoulders is not medically necessary.

Halcion 0.125 mg, count 30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Benzodiazepines Page(s): 24.

Decision rationale: The California MTUS guidelines note Benzodiazepines are not recommended for long-term use because long-term efficacy is unproven and there is a risk of dependence; most guidelines limit use to 4 weeks. Their range of action includes sedative/hypnotic, anxiolytic, anticonvulsant, and muscle relaxant. Chronic Benzodiazepines are the treatment of choice in very few conditions. Tolerance to hypnotic effects develops rapidly. Tolerance to anxiolytic effects occurs within months and long-term use may actually increase anxiety; a more appropriate treatment for anxiety disorder is an antidepressant. Tolerance to anticonvulsant and muscle relaxant effects occurs within weeks. Within the provided documentation, the requesting physician's rationale for the request was not indicated. There is a lack of documentation indicating the injured worker has significant objective functional improvement with the use of the medication. There is a lack of documentation indicating how long the injured worker has been prescribed this medication. Additionally, the frequency at which the medication is prescribed is not indicated in order to determine the medical necessity of the medication. As such, the request for Halcion 0.125 mg, count 30 is not medically necessary.

Voltaren Gel 1% 40 gm tube, count 5: Upheld

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

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

Decision rationale: The California MTUS guidelines recommend the use of NSAIDs for topical application for osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder and use with neuropathic pain is not recommended as there is no evidence to support use. Voltaren Gel 1% is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee and wrist) per the guidelines. Per the provided documentation there is a lack of documentation indicating the injured worker has a diagnosis of osteoarthritis or tendinitis, in particular, that to a joint that is amenable to topical treatment. The requesting physician's rationale for the request is unclear. The physician noted the injured worker had improvement in pain with the Voltaren gel; however, the physician did not provide significant objective data demonstrating functional improvement with the medication. Additionally, the physician did not indicate the frequency at which the medication was prescribed, as well as the site at which it is to be applied, in order to determine the medical necessity of the medication. As such, the request for Voltaren Gel 1% 40 gm tube, count 5 is not medically necessary.