

Case Number:	CM14-0157717		
Date Assigned:	10/01/2014	Date of Injury:	03/20/2000
Decision Date:	10/30/2014	UR Denial Date:	08/26/2014
Priority:	Standard	Application Received:	09/25/2014

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, has a subspecialty in Interventional Spine 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 68 years old female with an injury date on 03/20/2000. Based on the 08/03/2014 progress report provided by [REDACTED], the diagnoses are: 1. Stable phase musculoskeletal pain, no functional change 2. Regional musculoskeletal pain 3. Cervical spondylosis 4. Right shoulder impingement syndrome 5. Right wrist tendinitis 6. Lumbar spondylosis 7. Right knee chondromalacia. According to this report, the patient complains of neck, right wrist, low back, and right knee pain. Physical exam reveals decreased cervical range of motion. Tenderness and spasm are noted over the cervical/lumbar paraspinal muscles, suprascapular muscle, upper trapezius, and bilateral supraclavicular area. Mild tenderness is noted over the right medial knee and right medial epicondyle of the wrist. The 06/20/2014 report indicates positive Neer test with weakness, positive patellar apprehension test. There were no other significant findings noted on this report. The utilization review denied the request on 08/26/2014. [REDACTED] is the requesting provider, and he provided treatment reports from 11/08/2013 to 09/05/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Duexis, take 1 tablet three times daily as needed pain #90 with two refills: 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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation pain chapter under Duexis® (ibuprofen & famotidine)

Decision rationale: According to the 08/03/2014 report by [REDACTED] this patient presents with neck, right wrist, low back, and right knee pain. The treater is requesting Duexis #90 with 2 refills. Duexis was first mentioned in the 11/08/2013 report; it is unknown exactly when the patient initially started taking this medication. The MTUS and ACOEM Guidelines do not address Duexis; however, ODG Guidelines states "Not recommended as a first-line drug. Horizon Pharma recently announced the launch of Duexis, a combination of ibuprofen 800 mg and famotidine 26.6 mg, indicated for rheumatoid arthritis and osteoarthritis." MTUS also does not recommend routine use of PPI's for prophylactic use without a proper GI risk assessment. Review of the reports do not show GI risk assessment. First line treatment with Duexis is also not recommended. Recommendation is for denial.

Cymbalta 30mg take 1 capsule once daily #30 with two refills: 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 Duloxetine (Cymbalta) Page(s): 16 and 17.

Decision rationale: According to the 08/03/2014 report by [REDACTED] this patient presents with neck, right wrist, low back, and right knee pain. The treater is requesting Cymbalta 30mg, #30 with 2 refills. Cymbalta was first mentioned in the 11/08/2013 report. For Cymbalta, the MTUS Guidelines page 16 and 17 states, "Duloxetine (Cymbalta) is FDA-approved for anxiety, depression, diabetic neuropathy, and fibromyalgia. It is also used for off-label neuropathic pain and radiculopathy. Duloxetine is recommended as a first line option for diabetic neuropathy." In this case, medical records do not document neuropathic pain such as numbness and tingling. Also, the patient does not presents with anxiety and depression. Furthermore, there was no discussion of the efficacy of the medication. MTUS page 60 require that medication efficacy in terms of pain reduction and functional gains must be discussed when used for chronic pain. Recommendation is for denial.

Lidoderm 5% apply 1 to 2 patches x 12 hours as needed pain #30 with two refills: Upheld

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

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

Decision rationale: According to the 08/03/2014 report by [REDACTED] this patient presents with neck, right wrist, low back, and right knee pain. The treater is requesting Lidoderm 5% patches, #30 with 2 refills. Lidoderm was first mentioned in the 11/08/2013 report; it is unknown exactly when the patient initially using taking this patches. The MTUS guidelines state that Lidoderm patches may be recommended for neuropathic pain that is peripheral and localized when trials of antidepressants and anti-convulsants have failed. Review of the reports show the patient has upper extremity neuropathic pain but is not localized. Furthermore, the treater does not discuss how this patch is used and with what effect. MTUS page 60 require documentation of pain and function when medications are used for chronic pain. Recommendation is for denial.

Mineral ice gel apply three times daily as needed pain #8oz with two refills: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation low back chapter on Biofreeze

Decision rationale: According to the 08/03/2014 report by [REDACTED] this patient presents with neck, right wrist, low back, and right knee pain. The treater is requesting mineral ice gel, #802 with 2 refills. Mineral ice gel contains menthol and it was first mentioned in the 11/089/2013 report. The utilization review denial letter states The ACOEM per MTUS guidelines indicates that oral pharmaceuticals are the first treatment, and there is no documentation of intolerance to oral medications. Regarding topical analgesics, MTUS does not specifically discuss menthol. ODG guidelines were consulted. ODG guidelines state recommended for acute pain and takes the place of an ice pack for cryotherapy. In this case, the patient is not in the acute phase, and the use of menthol for a chronic condition is not in accordance with the ODG recommendations. Menthol would not be recommended for a chronic condition. Recommendation is for denial.

Continue use of H-wave: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H-wave stimulation (HWT).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H-Wave Page(s): 117, 118.

Decision rationale: According to the 08/03/2014 report by [REDACTED] this patient presents with neck, right wrist, low back, and right knee pain. The treater is requesting mineral ice gel, #802 with 2 refills. Mineral ice gel contains menthol and it was first mentioned in the 11/089/2013 report. The utilization review denial letter states "The ACOEM per MTUS guidelines indicates that oral pharmaceuticals are the first treatment, and there is no documentation of intolerance to oral medications." Regarding topical analgesics, MTUS does not specifically discuss menthol. ODG guidelines were consulted. ODG guidelines state recommended for acute pain and takes the place of an ice pack for cryotherapy. In this case, the

patient is not in the acute phase, and the use of menthol for a chronic condition is not in accordance with the ODG recommendations. Menthol would not be recommended for a chronic condition. Recommendation is for denial.

Continue use gym exercise program: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines gym exercise program Page(s): 46-47. Decision based on Non-MTUS Citation Exercise for Chronic pain

Decision rationale: According to the 08/03/2014 report by [REDACTED] this patient presents with neck, right wrist, low back, and right knee pain. The treater is requesting continue use gym exercise program. The utilization review denial letter states "there is no clear rationale provided as to why the patient is unable to perform an effective home exercise program or why the patient requires equipment for exercise." MTUS pages 46-47 state that exercise is recommended and that, "There is strong evidence that exercise programs, including aerobic conditioning and strengthening, are superior to treatment programs that do not include exercise. There is no sufficient evidence to support the recommendation of any particular exercise regimen over any other exercise regimen. In this case, one type of exercise is not superior to another. Recommendation is for denial.

Continue elastic band exercises: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines elastic band exercise Page(s): 46-47.

Decision rationale: According to the 08/03/2014 report by [REDACTED] this patient presents with neck, right wrist, low back, and right knee pain. The treater is requesting continue elastic band exercise. According to the 08/03/2014 report by [REDACTED] this patient presents with neck, right wrist, low back, and right knee pain. The treater is requesting continue use gym exercise program. The utilization review denial letter state there is no clear rationale provided as to why the patient is unable to perform an effective home exercise program or why the patient requires equipment for exercise." MTUS pages 46-47 state that exercise is recommended and that, "There is strong evidence that exercise programs, including aerobic conditioning and strengthening, are superior to treatment programs that do not include exercise. There is no sufficient evidence to support the recommendation of any particular exercise regimen over any other exercise regimen." ODG further states under durable medical equipment that it must be primarily and customarily used to serve a medical purpose and generally not useful to a person in the absence of illness. In this case, one type of exercise is not superior to another. Recommendation is for denial.

