

Case Number:	CM14-0158932		
Date Assigned:	10/02/2014	Date of Injury:	10/11/2012
Decision Date:	11/12/2014	UR Denial Date:	09/15/2014
Priority:	Standard	Application Received:	09/29/2014

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 Neuromuscular Medicine and is licensed to practice in Maryland. 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 50 year old female with a work injury dated 10/11/12. The diagnoses include cervical spine disc protrusion; thoracic spine disc protrusion; lumbar spine herniated nucleus pulposus; right carpal tunnel syndrome; left hip pain; left knee chondromalacia and meniscal tear; hypertension; insomnia; stress. Under consideration are requests for electro-acupuncture QTY: 12.00; 1 prescription for Menthoderm gel QTY: 1.00; 1 prescription for omeprazole 20mg QTY: 30.00; 1 request for a NIOSH QTY: 1.00; shock wave therapy QTY: 1.00. There is a 7/28/14 PR-2 document that is handwritten and mostly illegible that states that the patient's cervical, thoracic, and left hip pain are 1/10. The bilateral wrist/hand pain is 8/10. The left knee pain is 5/10. The lumbar spine pain is 4/10. There is numbness/tingling in the bilateral upper and lower extremities. The pain is decreased with topical medications. On exam there is a Positive Kemp's bilaterally. There is a negative straight leg raise. There is decreased range of motion of wrist, The rest is illegible Treatment: Re-evaluation pain management; orthopedic follow up; physical therapy, NIOSH; remain off of work. Per documentation a 6/2/14 prescription of Menthoderm (Methyl Salicylate 15%/Menthol 10%) was prescribed for the patient.

IMR ISSUES, DECISIONS AND RATIONALES

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

electro-acupuncture QTY: 12.00: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The guidelines state that improvement can usually be seen after 3 to 6 acupuncture treatments. Acupuncture treatments may be extended if functional improvement is documented as defined in Section 9792.20. The documentation is not clear what conditions the acupuncture is being requested for and also whether the patient has had prior electro acupuncture and the outcomes. The request exceeds the recommended trial period and is not medically necessary. The request for Electro-acupuncture Qty: 12.00 is not medically necessary.

1 prescription for Mentherm gel QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Salicylate topical, Topical analgesics Page(s): 105, 111-113.

Decision rationale: Per MTUS Chronic Pain Medical Treatment Guidelines. Mentherm is Methyl Salicylate 15%/Menthol 10%. The documentation indicates that the patient has been using Mentherm without evidence of functional improvement as defined by the MTUS. The MTUS states that salicylate are significantly better than placebo in chronic pain. The MTUS states that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The documentation indicates that the patient has been using Mentherm without evidence of functional improvement as defined by the MTUS. The documentation does not indicate intolerance of oral medications. The request for Mentherm gel QTY:1 is not medically necessary.

1 prescription for omeprazole 20mg QTY: 30.00: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI symptoms & cardiovascular risk Page(s): 68-69.

Decision rationale: The guidelines state that a patient has risk factors for gastrointestinal events if they have the following risk factors: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). The documentation does not support proton pump inhibitors in the absence of these risk factors or dyspepsia from NSAIDS. The request for 1 prescription of Omeprazole 20mg QTY:30 is not medically necessary.

1 request for a NIOSH QTY: 1.00: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.cdc.gov/niosh/>

Decision rationale: The MTUS and ODG guidelines do not address NIOSH. A review online of NIOSH indicates that this is The National Institute for Occupational Safety and Health (NIOSH). The documentation is not clear as to what is being requested and why this is medically necessary. Without further information and clarification the request for NIOSH Qty: 1.00 is not medically necessary.

shock wave therapy QTY: 1.00: 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) Low Back, Lumbar and thoracic (Acute & Chronic)-shock wave therapy

Decision rationale: The documentation indicated that shock wave therapy was for the low back and the patient has received this for the thoracic area. The MTUS is silent on shockwave for the low back. The ODG states that there is no evidence to use shockwave therapy for the lumbar spine. The request for shock wave therapy QTY:1 is not medically necessary.