

Case Number:	CM14-0170308		
Date Assigned:	10/30/2014	Date of Injury:	11/15/2012
Decision Date:	12/16/2014	UR Denial Date:	09/24/2014
Priority:	Standard	Application Received:	10/15/2014

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 Orthopedic Surgery, 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:

51-year-old female with reported industrial injury reported 11/15/12. Exam note 5/30/14 demonstrates complaints of neck pain which is sharp and stabbing pain. Left shoulder pain is noted with radiation down the arm to the fingers with spasms. Range of motion is noted to be 150 degrees of flexion with 40 degrees of extension with 150 degrees of abduction. The left wrist and hand complaints are noted to include burning pain. There is pain noted in the upper, mid back, low back pain. Examination demonstrates tenderness over the left shoulder, left wrist with decreased motor strength secondary to pain in the bilateral upper extremities.

IMR ISSUES, DECISIONS AND RATIONALES

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

Six (6) Continue Shockwave Therapy Sessions: 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) Low Back

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

Decision rationale: CA MTUS/ACOEM is silent on the issue of shockwave therapy. According to ODG, Shoulder section, extracorporeal shock wave therapy (ESWT), it is recommended for calcific tendonitis but not for other shoulder disorders. The exam note from 5/30/14 does not demonstrate evidence of calcific tendonitis with failure of conservative treatment. Therefore the determination is not medically necessary.

Six LINT- lumbar spine visits: 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)

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

Decision rationale: CA MTUS/ACOEM is silent on the issue of E&M services. According to the ODG, Pain section, office visits, "Recommended as determined to be medically necessary. Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment." In this case there is insufficient evidence in the records of 5/30/14 to justify 6 visits. Therefore determination is not medically necessary.

Referral to Ortho surgeon: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7, page 127

Decision rationale: Per the CA MTUS ACOEM 2004, Chapter 7, page 127 states the occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial facts are present, or when the plan or course of care may benefit from additional expertise. In this case the records cited do not demonstrate any specific orthopedic condition or failure of conservative care to warrant a specialist referral. Therefore the determination is not medically necessary.

Prescription 500ml Synapryn 10 mg/1ml: 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 Glucosamine, Tramadol Page(s): 50, 91-94.

Decision rationale: CA MTUS/Chronic Pain Medical Treatment Guidelines, Glucosamine, page 50 and opioids, Tramadol, page 91-94 is most applicable. It is noted that Synapryn is a compounded medication with Glucosamine. CA MTUS/Chronic Pain Medical Treatment Guidelines, Glucosamine (and Chondroitin Sulfate), page 50, states, "Recommended as an option given its low risk, in patients with moderate arthritis pain, especially for knee osteoarthritis". In this case there is lack of evidence of knee osteoarthritis from the exam note of 5/30/14 demonstrating knee osteoarthritis. Therefore the determination is not medically necessary.

Prescription 250ml Tabradol 1mg/ml: 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 Cyclobenzaprine Page(s): 41-42.

Decision rationale: Tabradol is an oral suspension of Cyclobenzaprine. According to the CA MTUS, Chronic Pain Medical Treatment Guidelines, pages 41-42 "Recommended as an option, using a short course of therapy. Cyclobenzaprine (Flexeril) is more effective than placebo in the management of back pain; the effect is modest and comes at the price of greater adverse effects. The effect is greatest in the first 4 days of treatment, suggesting that shorter courses may be better. (Browning, 2001) Treatment should be brief. There is also a post-op use. The addition of Cyclobenzaprine to other agents is not recommended." In this particular case the patient has no evidence in the records of 5/30/14 of functional improvement, a quantitative assessment on how this medication helps percentage of relief lasts, increase in function, or increase in activity. Therefore chronic usage is not supported by the guidelines. Therefore this request is not medically necessary.

Prescription 250ml Deprizine 15mg/ml: 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 NSAIDS, GI symptoms and cardiovascular risk Page(s): 68-69.

Decision rationale: Deprizine is an oral suspension of Ranitidine which is an H2 antagonist. Per the CA MTUS/Chronic Pain Medical Treatment Guidelines, Use of NSAIDS, GI symptoms and cardiovascular risk, pages 68-69, H2 antagonists are indicated for the treatment of dyspepsia secondary to NSAID therapy. In this case the exam notes from 5/30/14 do not demonstrate the patient has peptic ulcer disease, GERD or is at increased risk for gastric ulcer. Therefore the determination is not medically necessary.

Prescription 150ml Dicopanol 5 mg/ml: 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 Specific Anti-Epilepsy Drugs Page(s): 18.

Decision rationale: Dicopanol is an oral suspension of Gabapentin. Per the CA MTUS Chronic Pain Treatment Guidelines page 18, Specific Anti-Epilepsy Drugs, Neurontin is indicated for diabetic painful neuropathy and postherpetic neuralgia and is considered first line treatment for neuropathic pain. In this case, the exam note from 5/30/14 does not demonstrate evidence neuropathic pain or demonstrate percentage of relief, the duration of relief, increase in function or increased activity. Therefore medical necessity has not been established, and determination is not medically necessary.

Prescription 420ml Fanatrex (Gabapentin) 25 mg/ml: 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 Specific Antiepilepsy drugs Page(s): 18.

Decision rationale: Fanatrex is an oral suspension of Gabapentin. Per the CA MTUS Chronic Pain Treatment Guidelines page 18, Specific Anti-Epilepsy Drugs, Neurontin is indicated for diabetic painful neuropathy and postherpetic neuralgia and is considered first line treatment for neuropathic pain. In this case, the exam note from 5/30/14 does not demonstrate evidence neuropathic pain or demonstrate percentage of relief, the duration of relief, increase in function or increased activity. Therefore medical necessity has not been established, and determination is not medically necessary.