

Case Number:	CM14-0039397		
Date Assigned:	07/30/2014	Date of Injury:	08/20/2013
Decision Date:	08/29/2014	UR Denial Date:	03/27/2014
Priority:	Standard	Application Received:	04/03/2014

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 Illinois. 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 67-year-old female who reported an injury due to repetitive use on 08/20/2013. The clinical note, not dated, indicated diagnoses of right shoulder bursitis/tendinosis and left hand/thumb pain. The injured worker reported right shoulder pain rated 8/10, diffuse to the elbow, left hand pain, thumb pain rated 8/10. The injured worker reported treatments and medications were helping. On physical examination, there was tenderness to the right shoulder with limited range of motion and tenderness to the left hand and thumb with hypoesthesia to C1 dermatomes. The injured worker's treatment plan included a pain management referral, topical creams, chiropractic therapy, acupuncture, urinalysis, and a followup appointment in 4 weeks. The injured worker's prior treatments included physical therapy and medication management. The injured worker's medication profile was not submitted for review. The provider submitted a request for chiropractic sessions, tramadol, omeprazole, cyclobenzaprine, and topical compound prescriptions. A Request for Authorization dated 03/08/2014 was submitted. However, a rationale was provided for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractor sessions 2 times per week for 4 weeks in treatment of the right shoulder:
Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
MANUAL THERAPY & MANIPULATION Page(s): 58.

Decision rationale: The request for Chiropractor sessions 2 times per week for 4 weeks in treatment of the right shoulder is not medically necessary. The CA MTUS guidelines recommend manual therapy for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. It was indicated that the injured worker had prior physical therapy. However, there is a lack of documentation indicating the injured worker had significant objective functional improvement with the prior therapy. In addition, there is a lack of documentation regarding a complete physical exam to evaluate for decreased functional ability, decreased range of motion, and decreased strength and flexibility. Moreover, it was not indicated if the injured worker had participated in chiropractic therapy. Therefore, the request for chiropractic therapy is not medically necessary.

Tramadol: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
TRAMADOL (ULTRAM) Page(s): 113.

Decision rationale: The request for Tramadol is not medically necessary. The California MTUS guidelines state tramadol (Ultram) is a centrally acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic. It was not indicated if the injured worker had been utilizing this medication or if this was a trial prescription. In addition, tramadol is not recommended as a first line analgesic. Moreover, it was not indicated if the injured worker had tried a first line analgesic. Furthermore, the request did not indicate a dosage, frequency, or quantity. Therefore, the request is not medically necessary.

Omeprazole: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS,
GI SYMPTOMS & CARDIOVASCULAR RISK Page(s): 68.

Decision rationale: The request for Omeprazole is not medically necessary. The CA MTUS guidelines recommend the use of proton pump inhibitors if there is a history of gastrointestinal bleeding or perforations, a prescribed high dose of NSAIDs and a history of peptic ulcers. There

is also a risk with long-term utilization of PPI (> 1 year) which has been shown to increase the risk of hip fracture. There is a lack of clinical information provided indicating the injured worker has gastritis. In addition, there is a lack of documentation of NSAID side effects reported by the injured worker that would warrant the use of a proton pump inhibitor. Moreover, it was not indicated if the injured worker had been utilizing this medication. Additionally, there was lack of documentation of any medication the injured worker was taking. Therefore, it was unable to be determined if any medication would warrant the use of a proton pump inhibitor. In addition, the request did not indicate a dosage, frequency, or quantity. The injured worker also fails to fit the criteria of any significant risk for gastrointestinal bleeding or perforation. Therefore, the request for omeprazole is not medically necessary.

Cyclobenzaprine: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CYCLOBENZAPRINE (FLEXERIL) Page(s): 41-42.

Decision rationale: The request for Cyclobenzaprine is not medically necessary. The CA MTUS guidelines recommend cyclobenzaprine (Flexeril) as an option, using a short course of therapy. Cyclobenzaprine is a skeletal muscle relaxant and a central nervous system (CNS) depressant. It was not indicated if the injured worker had been utilizing this medication, or if this was for a trial prescription. In addition, there was lack of documentation of any medication the injured worker was taking. Therefore, it was unable to be determined if the injured worker would warrant the use of this medication. Moreover, the request does not indicate a dosage, frequency, or quantity. Additionally, the documentation submitted did not indicate the injured worker had findings that would support she was at risk for muscle spasms or acute exacerbations of the low back. Therefore, the request for cyclobenzaprine is not medically necessary.

Topical Compound prescription medications (unspecified) x 2: Upheld

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

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

Decision rationale: The request for Topical Compound prescription medications (unspecified) x 2 is not medically necessary. The California Chronic Pain Medical Treatment Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. It is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The guidelines also indicate any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Ketoprofen is not currently FDA approved for a topical application. The guidelines do not recommend the topical use of Cyclobenzaprine as topical muscle relaxants as

there is no evidence for use of any other muscle relaxant as a topical product. The guidelines indicate that topical lidocaine (Lidoderm) may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). Topical compounds are largely experimental, and it was not indicated if the injured worker had tried and failed antidepressants and anticonvulsants. In addition, Ketaprofen is not FDA approved as a topical agent, and the guidelines do not recommend cyclobenzaprine. Per the guidelines, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Lidocaine is only recommended in the form of the dermal patch, Lidoderm. No other commercially approved topical formulations of lidocaine, whether creams, lotions, or gels, are indicated for neuropathic pain. In addition, the request did not indicate the type of compound prescription, the dosage, or frequency. Moreover, the provider did not indicate a rationale for the request. Additionally, it was not indicated if the injured worker had been utilizing this medication. Therefore, the request is not medically necessary.