

Case Number:	CM14-0042566		
Date Assigned:	08/06/2014	Date of Injury:	09/29/2005
Decision Date:	09/12/2014	UR Denial Date:	03/11/2014
Priority:	Standard	Application Received:	04/08/2014

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 Mississippi. 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 records, presented for review, indicate that this 52 year old female was reportedly injured on September 29, 2005. The mechanism of injury was noted as repetitive stress type situation. The most recent progress note, dated June 12, 2014, indicated that there were ongoing complaints of neck and back pain, reportedly 50 percent improvement. The physical examination demonstrated a limited range of motion of both the cervical spine and lumbar spine. Diagnostic imaging studies of a Discogram were suggested. Previous treatment included surgical intervention, medications, injection therapies and braces. A request was made for plasma rich protein injections in the multiple regions and multiple medications and was not certified in the pre-authorization process on March 11, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Platelet Rich Plasma (PRP) Bilateral Thumbs Injection: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Forearm, Wrist & Hand (Acute & Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Forearm, Wrist & Hand updated August 2014.

Decision rationale: The Official Disability Guidelines (ODG) indicates that such injections are not recommended as there are no studies to demonstrate the efficacy of the utility of this type of injection into the carpometacarpal joint. Therefore, when noting the limited clinical information presented for review relative to the thumbs and the parameters outlined in the ODG, this is not medically necessary.

Platelet Rich Plasma (PRP) Lumbar Disc Injection: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Pain (Chronic).

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 chapter, updated August, 2014.

Decision rationale: As noted in the Official Disability Guidelines (ODG) were used and these indicate that such an injection is not recommended. It is of their ongoing complaints of low back pain and additional imaging studies are being sought. However, there is no medical necessity established for platelet rich plasma (PRP) injection into the lumbar spine. Therefore the request is not medically necessary.

Cervical Facet Block with Radiofrequency: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back (Acute & Chronic).

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) PRF, page 102/127.

Decision rationale: As noted in the American College of Occupational and Environmental Medicine (ACOEM), branch blocks are considered when facet rhizotomy is on the horizon. It is noted there are ongoing complaints of neck pain, and the physical examination reported is equivocal. There is no objectification for the need for facet joints based on the limited progress notes presented for review. Therefore, based on these limited clinical data, this is not medically necessary.

Soma 350mg, #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Carisoprodol Page(s): 29 OF 127.

Decision rationale: As noted in the Medical Treatment Utilization Schedule (MTUS), this medication is not recommended. Furthermore, this is clearly not indicated for long term use. The progress notes indicate that this is going to be used indefinitely. There is no noted efficacy identified in the progress notes reviewed. As such, there is no clinical indication for the ongoing use. Furthermore, when noting the side effect profile and the metabolites of this medication, it is clear this medication is not medically necessary.

Lidoderm Patches 5%, #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s):
56 OF 127.

Decision rationale: The records indicate that there is an ongoing investigation to establish the pain generator in the back. This is demonstrated by seeking out a Discogram for the cervical spine. As such, there is no objectified neuropathic lesion. The Medical Treatment Utilization Schedule (MTUS) establishes that this medication is identified as a first line therapy for neuropathic pain. In as much as the exact pain generator has not been established, there is no clear clinical indication for the continued use of this medication. As such, this is not medically necessary.

Opana 10mg, #210: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Opioids, Oxymorphone-3. Decision based on Non-MTUS Citation Official Disability
Guidelines, Pain (Chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s):
74, 78, 93 of 127.

Decision rationale: As outlined in the Medical Treatment Utilization Schedule (MTUS), there is support for short acting opiate for the short term management of moderate to severe breakthrough pain. However, this medication is intended for chronic, indefinite use. While noting ongoing complaints of pain, the progress notes reviewed, do not indicate that there has been any objectified efficacy with use of this medication in terms of increased functional, decreased symptomatology or amelioration of the pain complaints. Therefore, when noting this medication has failed to achieve its intended goals, the request is not medically necessary.

Opana ER 40mg, #150: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Oxymorphone-3. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 74, 78, 93 OF127.

Decision rationale: As outlined in the Medical Treatment Utilization Schedule (MTUS), there is support for short acting opiate for the short term management of moderate to severe breakthrough pain. However, this medication is intended for chronic, indefinite use. While noting ongoing complaints of pain, the progress notes reviewed, do not indicate that there has been any objectified efficacy with use of this medication in terms of increased functional, decreased symptomatology or amelioration of the pain complaints. Therefore, when noting this medication has failed to achieve its intended goals, the request is not medically necessary.

Zolpidem 10mg, #60: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG:) Pain chapter, updated August, 2014.

Decision rationale: The parameters noted in the Official Disability Guidelines (ODG) are used. This medication is a short acting non-benzodiazepine hypnotic medication approved for short term (two to six weeks) treatment of insomnia. The medical records do not demonstrate any efficacy relative to that indication. When noting there are ongoing complaints of pain, and the sick hygiene is a crucial component of pain management, there needs to be objective occasion of the efficacy of the medication in terms of the previously pattern. Seeing none, the medical necessity for this medication has not been established.