

Case Number:	CM14-0056445		
Date Assigned:	08/08/2014	Date of Injury:	04/29/2012
Decision Date:	09/11/2014	UR Denial Date:	03/26/2014
Priority:	Standard	Application Received:	04/25/2014

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 Occupational Medicine 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:

According to the available medical records, this is a 32-year-old woman injured on 4/29/12. She was carrying a plate of food and slipped on water causing her to fall backwards. She injured her shoulders, back and hips. Report of 2/21/14 that requested the current items under review was handwritten and difficult to read. There are pain ratings for the low back, bilateral shoulders, right thumb, bilateral hip and right foot and ankle. There is back pain, bilateral hip pain, bilateral lower extremity "radic" left shoulder pain improved after injection pain management consult points to bilateral sacroiliac joint as site of pain. Objective findings, limited range of motion low back, tenderness bilateral SI joints, negative straight leg raise, diagnose of lumbar sacral strain/sprain negative MRI; bilateral shoulder impingement negative MRI; bilateral thumbs sprain/strain; bilateral hip sacroiliac osteoarthritis bilateral; right foot/ankle sprain/strain. The progress report (PR)-2 that preceded this report of 1/21/13 had essentially the same pain ratings for the various body parts. A 3/24/14 PR-which was the follow-up after the current report also contains the same basic complaints and pain ratings. There is no mention of what the purpose of the pain management consult was. There is no mention of what body parts were to receive electric corporeal shock wave treatments or what the response to previous treatments has been. The reports mention prescription of multiple creams but there is never any mention that the patient got any functional benefit from those. Each report requested therapy 2x4 but never discussed what the patient's response to previous treatment was or what the ongoing goals for therapy were. There was no mention of what body parts were to be addressed. There is no mention of any acute flare-up of muscle spasm or exacerbation of the patient's chronic pain. There is no mention that the patient got any pain relief from the tramadol, no mention how many she used on the average day. Use of the medications and creams all appear to be chronic and greater than 90 days.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cyclobenzaprine 7.5 mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63. Decision based on Non-MTUS Citation Official Disability Guidelines Pain Chapter non-sedating muscle relaxants.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines part 2 Page(s): 63-64.

Decision rationale: MTUS Chronic Pain Guidelines only support a short course, 2-3 weeks for acute flareups of chronic muscle pain and spasm. There is no documentation in the current report of any flareup of the patient's symptoms; rather they appear to be ongoing on a month-to-month basis based upon the progress reports (PR)-2's. Thus, based upon the evidence and the guidelines, this is not considered to be medically necessary.

Tramadol 150 mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 79-81. Decision based on Non-MTUS Citation Official Disability Guidelines Pain Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Part 2 Page(s): 74-96.

Decision rationale: Use of this opiate analgesic has been chronic. There is no documentation that the patient gets any objective functional improvement from use. There is not even documentation that the patient takes this on a regular basis in order to justify the quantities being given regularly every month. There is no mention of ongoing monitoring of the patient for addiction, analgesia, or aberrant drug use. MTUS guidelines do not support continued chronic use of opioids without functional benefit. Therefore based upon the evidence and the guidelines this is not considered to be medically necessary.

FlurLido-A 30 grams: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Part 2 Page(s): 111-113.

Decision rationale: MTUS chronic pain guidelines do not support topical use of lidocaine except in patch formulation nor is the anti-inflammatory flurbiprofen supported for topical use.

Guidelines also state that "any compounded product that contains at least one drug or drug class that is not recommended is not recommended." There is no information available to support use outside of guidelines. Based on the evidence and the guidelines, this is not medically necessary.

Ultraflex-G 30 grams: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Part 2 Page(s): 111-113.

Decision rationale: Per the 1/21/14 report, this contains gabapentin, cyclobenzaprine and tramadol. MTUS Chronic Pain Guidelines do not support topical use, the anti-epileptic gabapentin, the muscle relaxant cyclobenzaprine and the analgesic tramadol. Guidelines also state that "any compounded product that contains at least one drug or drug class that is not recommended is not recommended." There is no information available to support use outside of guidelines. Based on the evidence and the guidelines, this is not medically necessary.

Flurbiprofen 20%/ Tramadol 20%/ Cyclobenzaprine 4% #240 grams: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Part 2 Page(s): 111-113.

Decision rationale: MTUS chronic pain guidelines do not support topical use of the analgesic tramadol, the muscle relaxant cyclobenzaprine or the nonsteroidal anti-inflammatory medication fluribiprofen. Guidelines also state that any compounded product that contains at least one drug or drug class that is not recommended is not recommended. There is no information available to support use outside of guidelines. Based on the evidence and the guidelines, this is not medically necessary.

Physiotherapy two (2) times weekly for four (4) weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Passive therapy Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (<http://www.odg-twc.com/preface.htm#PhsicalTherapyGuidelines>)(Low Back Chapter).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Part 2 Page(s): 98-99.

Decision rationale: In the treatment of chronic pain, MTUS guidelines support up to 10-12 sessions and transition to independent home exercise program. Documents provided indicate that

this patient has Physical Therapy 2 x 4 on a monthly basis that is ongoing. This exceeds MTUS Chronic Pain Guidelines in terms of number of sessions and furthermore, continues despite no evidence of any objective functional benefit. Thus, based upon the evidence and guidelines, this is not considered to be medically necessary.

Referral to Pain management: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 127. Decision based on Non-MTUS Citation Official Disability Guidelines, Evaluation and management, Low Back Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 288, 306. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 12 pages 288 and 306; Chapter 7 page 127.

Decision rationale: There was an initial pain management consultation on 10/7/13 and there is no rationale for another consultation. There's also no indication that the patient is a candidate for invasive pain management treatment or that medication management is particularly complex. ACOEM only supports; specialty consultation to aid in the diagnosis, therapeutic management, determination of of permanent residual loss or impairment, none if which is mentioned in the requesting report. Therefore, based upon the evidence and the guidelines, this is not considered to be medically necessary.

Amitriptyline 10%/ Dextromethorphan 10%/ Gabapentin 10% #240 grams: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Part 2 Page(s): 111-113.

Decision rationale: MTUS Chronic Pain Guidelines do not support topical use of the tricyclic antidepressant amitriptyline, the antiepileptic gabapentin or cough suppressant dextromethorphan. Guidelines also state that "any compounded product that contains at least one drug or drug class that is not recommended is not recommended." There is no information available to support use outside of guidelines. Based on the evidence and the guidelines, this is not medically necessary.

ECSWT (extracorporeal shock wave therapy) one (1) time weekly for six (6) weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Extracorporeal Shock Wave Therapy for Orthopedic Conditions.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Extra Corporeal Shockwave Therapy Other Medical Treatment Guideline or Medical Evidence: Aetna Clinical Policy Bulletin: Extra corporeal Shock-Wave Therapy for Musculoskeletal Indications and Soft Tissue Injuries (http://www.aetna.com/cpb/medical/data/600_699/0649.html).

Decision rationale: MTUS guidelines do not address this treatment. Official Disability Guidelines (ODG) only addresses use of this treatment for calcific tendinitis of the shoulder and plantar faciitis of the foot. This patient has neither of those diagnoses. No other body parts are addressed for treatment by extra corporeal shock wave by ODG. Aetna's clinical policy bulletins consider this treatment to be experimental and investigational. Additionally, the treatment appears to be ongoing without evidence of any objective functional benefit. Thus, based upon the evidence, guidelines and references this is not considered be medically necessary.