MAXIMUS Federal Services

Case Number:	CM14-0063850		
Date Assigned:	08/06/2014	Date of Injury:	04/08/2005
Decision Date:	09/19/2014	UR Denial Date:	04/09/2014
Priority:	Standard	Application Received:	05/06/2014

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 Nevada. 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 56-year-old individual was reportedly injured on April 8, 2005. The mechanism of injury was noted as a cumulative trauma type situation. The most recent progress note, dated June 30, 2014, indicated that there were ongoing complaints of neck pain, bilateral shoulders pain, and bilateral wrists pain. There were no complaints of abdominal pain with this evaluation. The physical examination demonstrated a well-developed, well-nourished individual in moderate to severe discomfort. The cervical spine examination noted tenderness to palpation and a slight decrease in range of motion. The bilateral shoulders were tender to palpation, and again the range of motion was slightly reduced. There was tenderness over the dorsal aspect of the wrist. A slight range of motion loss was noted. The injured worker was able to heel and toe walk; however, there was tenderness to palpation over the lower lumbar region. Diagnostic imaging studies were not reviewed. Previous treatment included shoulder surgery, electric shock wave therapy, physical therapy, multiple medications, and additional pain management interventions. A request had been made for multiple medications and was not certified in the pre-authorization process on April 8, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS Unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300,Chronic Pain Treatment Guidelines TENS (Transcutaneous Electrical Nerve Stimulation).

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

Decision rationale: The MTUS recommends against using a TENS unit as a primary treatment modality and indicates that a one-month trial must be documented prior to purchase of the unit. Based on the clinical documentation provided, the TENS unit is being used as a primary treatment modality, and there is no documentation of a previous one-month trial. Furthermore, the MTUS notes that an appropriate trial should include documentation of how often the unit was used, the outcomes in terms of pain relief and reduction, and there is no noted efficacy provided (increased functionality, decreased symptomatology or lessening of the pain complaints) in the progress notes presented for review. As such, the request for purchase of a TENS unit is considered not medically necessary.

Hot and Cold Therapy Unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Continuous Flow Cryotherapy. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 162, 300.

Decision rationale: The guidelines note there were many forms of heat therapy use. However, there is no documentation in the progress notes reviewed that there is any efficacy or utility with such a modality. A home exercise protocol emphasizing overall fitness, conditioning, achieving ideal body weight and maximum or spinal flexibility is supported, but there is no data to suggest that this type of modality was used or that it was successful. Therefore, the medical necessity is not established.

Functional Capacity Evaluation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Fitness for Duty.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 49. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

Decision rationale: ACOEM practice guidelines support the use of functional capacity evaluations (FCE) when necessary to translate medical evidence of functional limitations to determine work capability. There is no data to suggest that this individual is even contemplating returning to work. The ODG details the recommendation to consider a FCE if the patient has

evidence of prior unsuccessful return to work attempts or there is conflicting medical reporting on precautions and/or fitness for a modified job or if the patient's injuries are such that require a detailed exploration of the workers abilities. Review, of the available medical records, does not support any reduction in the pain complaints or increase in functionality that would allow for such a return to work. Therefore, the medical necessity of this intervention has not been established.

Ketoprofen 20% 120g: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical NSAID's.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical NSAIDs.

Decision rationale: MTUS guidelines support topical NSAIDs for the short-term treatment of osteoarthritis and tendinitis for individuals unable to tolerate oral non-steroidal anti-inflammatories. Based on the medical records reviewed, this is a blend of the case. Furthermore, the guidelines support 4-12 weeks of topical treatment for joints that are amendable to topical treatments; however, there is little evidence to support treatment of osteoarthritis of the spine, hips or shoulders. When noting the claimant's diagnosis, date of injury and clinical presentation, this request is not considered medically necessary. Objectively, there are reported successes, but objectively, based on the physical examination reported, there is no efficacy or utility with the continued use of this preparation. Therefore, when noting the parameters outlined in the guidelines and by the physical examination offered, this is not medically necessary.

Cyclophene 5% 120g: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 41, 64.

Decision rationale: MTUS Guidelines support the use of skeletal muscle relaxants for the short-term treatment of a flare-up of the pain but advises against long-term use. Given the claimant's date of injury and clinical presentation, the guidelines do not support this request for chronic pain. Furthermore, based on the physical examination reported, it does not appear to be any indication that this medication has any efficacy or utility. As such, the request is not medically necessary.

Synapryn 10mg/1 ml 500ml: 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 Tramadol (Ultram) Page(s): 82, 113.

Decision rationale: This is a centrally acting synthetic opioid analgesic suggested as a 2nd line treatment for pain. This medication is tramadol (Ultram) in an oral suspension. The guidelines note that this is indicated for short-term use when there is evidence of a first-line option is not been successful. However, it would appear that this is being employed in a chronic, indefinite scenario and is contrary to the parameters outlined in the MTUS. Additionally, based on the current complaints of pain and noting the findings on physical examination, there is no objectified or demonstrated efficacy or utility with the utilization of this product. Therefore, when noting the parameters outlined in the MTUS and with the findings on physical examination and taking note of the history, there is no data presented to support the ongoing use of this medication. This is not medically necessary.

Tabradol 1mg/ml 250ml: 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 Muscle relaxants Page(s): 41, 64.

Decision rationale: This medication is essentially cyclobenzaprine. This is a muscle relaxant indicated for short-term use of acute flares of musculoskeletal pain. There is no indication for the chronic or indefinite use and this is specifically not recommended for chronic use. Therefore, when noting the ongoing complaints of pain, the findings on physical examination, there is no data to suggest any efficacy or utility with the continued use of this medication. Therefore, the medical necessity has not been established.

Deprizine 15mg/ml 250ml: 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 (non-steroidal anti-inflammatory drugs) Page(s): 67, 68.

Decision rationale: This medication is a compound oral suspension preparation of a proton pump inhibitor. This medication is indicated for the treatment of gastroesophageal reflux disease or as a protectorant for non-steroidal medications. When noting the date of injury, the injury sustained, the current physical examination presented for review as well as the specific notation, there were no gastrointestinal complaints or findings on physical examination. There is simply no clinical indication presented for the medical necessity of this operation. Therefore, this is not clinically indicated or medically necessary.

Dicopanol 5mg 150ml: 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 Page(s): 65.

Decision rationale: Diphenhydramine (Dicopanol) is an oral suspension compounded medication to treat allergic reactions, motion sickness, and symptoms of Parkinson's disease. This medication is basically an antihistamine; the parameters for antihistamines are not noted and applicable in this clinical situation. Therefore, based on the clinical information presented, the medical necessity is not established.

Fanatrex 25mg/ml 420ml: 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 Antiepilepsy drugs (AEDs) Page(s): 16-18.

Decision rationale: This is an oral suspension compounded medication basically gabapentin. It is primarily indicated to treat seizures, and off label use has been noted to address neuropathic pain lesion. There are no specific neuropathic lesions identified in the progress notes presented for you. Furthermore, the pain complaints remain the same. As such, there is no noted efficacy with the utilization of this medication. Therefore, the medical necessity for this preparation has not been established.

3 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, Shoulder (Acute.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (acute and chronic) extracorporeal shockwave therapy.

Decision rationale: As outlined in the ODG, (the California MTUS and ACOEM Guidelines do not address) this procedure is limited to testifying tendinitis of the shoulder. The records reflect a number of sessions of having been completed, and the overall efficacy has not been demonstrated in terms of lesson pain or increased range of motion. Therefore, based on the records presented for review and by the parameters noted in the guidelines, there is no medical necessity established for repeating this intervention.

Terocin Patches (Unknown QTY and Dosage): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 112.

Decision rationale: Terocin topical pain lotion is a topical analgesic ointment containing methyl salicylate 25%, capsaicin 0.025%, menthol 10%, and lidocaine 2.50%. The MTUS notes that the use of topical medications is largely experimental and there have been few randomized controlled trials. It further goes on to note that topical lidocaine is a secondary option when trials of antiepileptic drugs or antidepressants have failed. Based on the clinical documentation provided, the claimant has not attempted a trial of either of these classes of medications. MTUS Guidelines indicate that when a single component is not indicated, the entirety is not indicated. As such, this request is considered not medically necessary.

Electromyography (EMG) of the Bilateral upper Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

Decision rationale: MTUS/ACOEM Guidelines support NCS in patients with clinical signs of carpal tunnel syndrome who may be candidates for surgery, but EMG is not generally necessary. After review of the available medical records, the claimant does not have a diagnosis of carpal tunnel syndrome and has not failed conservative treatment and steroid injections. Therefore, the standards relative to diagnostic testing are not met.

Electromyography (EMG) of the Bilateral Lower Extremities: 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 - Lumbar and Thoracic (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

Decision rationale: When considering the date of injury, the injury sustained, the findings on physical examination, there is no progressive neurological dysfunction or other indicator that would support the need for such an intervention. Therefore, based on the data presented, this is not medically necessary.

Nerve Conduction Velocity Study (NCV) of the Bilateral Upper Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

Decision rationale: MTUS/ACOEM Guidelines support NCS in patients with clinical signs of carpal tunnel syndrome who may be candidates for surgery, but EMG is not generally necessary. After review of the available medical records, the claimant does not have a diagnosis of carpal tunnel syndrome and has not failed conservative treatment and steroid injections. Therefore, the standards relative to diagnostic testing are not met.