

Case Number:	CM15-0101599		
Date Assigned:	06/01/2015	Date of Injury:	10/25/2013
Decision Date:	07/03/2015	UR Denial Date:	04/23/2015
Priority:	Standard	Application Received:	05/27/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 64-year-old male with an industrial injury dated 10/25/2013. The injured worker's diagnoses include cervical intervertebral disc disorder with myelopathy, thoracic intervertebral disc displacement without myelopathy, lumbar intervertebral disc disorder with myelopathy and shoulder rotator cuff syndrome. Treatment consisted of diagnostic studies, prescribed medications, and periodic follow up visits. In a progress note dated 04/10/2015, the injured worker reported pain in the left shoulder, bilateral wrist, bilateral hand, bilateral forearm, left elbow, cervical, upper thoracic, mid thoracic, lumbar, and right clavicular. The injured worker rated current pain a 6/10, 8/10 at worst and a 4/10 at best. The injured worker also reported numbness, tingling, anxiety and stress. Objective findings revealed tenderness to palpitation at cervical, thoracic, lumbar, sacroiliac, buttock, and shoulder. The treating physician prescribed services Magnetic Resonance Imaging (MRI) of bilateral shoulders and bilateral wrists, topical cream of Capsaicin 0.0375%, Tramadol 8%, Cyclobenzaprine 4%, Menthol 5%, Gabapentin 10% 180gms, urine drug screen and interferential stimulator home unit for chronic pain times 60 day trial, now under review. A utilization review determination dated April 23, 2015 recommends certification of physical therapy for the wrist, lumbar spine, and cervical spine. A urine drug screen performed on March 31, 2015 is negative for all tested substances.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of bilateral shoulders and bilateral wrists: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 207, 209, 269. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter, Magnetic resonance imaging (MRI), Forearm, Wrist, and Hand and Carpal Tunnel Syndrome Chapters.

Decision rationale: Regarding the request for MRI of bilateral shoulders and bilateral wrists, Occupational Medicine Practice Guidelines state that more specialized imaging studies are not recommended during the 1st month to 6 weeks of activity limitation due to shoulder symptoms except when a red flag is noted on history or examination. Cases of impingement syndrome are managed the same whether or not radiographs show calcium in the rotator cuff or degenerative changes are seen in or around the glenohumeral joint or AC joint. Guidelines go on to recommend imaging studies for physiologic evidence of tissue insult or neurovascular dysfunction, failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to an invasive procedure. ODG recommends MRI of the shoulder for subacute shoulder pain with suspicion of instability/labral tear or following acute shoulder trauma with suspicion of rotator cuff tear/impingement with normal plain film radiographs. Within the documentation available for review, it does not appear the patient has failed conservative treatment options. Furthermore, it is unclear how an MRI will change the patient's current treatment plan. In the absence of clarity regarding those issues, the currently requested MRI of bilateral shoulders and bilateral wrists is not medically necessary.

Topical cream, Capsaicin 0.0375%, Tramadol 8%, Cyclobenzaprine 4%, Menthol 5%, Gabapentin 10% 180gms times 1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R Page(s): 111-113 of 127.

Decision rationale: Regarding the request for Topical cream, Capsaicin 0.0375%, Tramadol 8%, Cyclobenzaprine 4%, Menthol 5%, Gabapentin 10% 180gms times 1, CA MTUS states that topical compound medications require guideline support for all components of the compound in order for the compound to be approved. Muscle relaxants drugs are not supported by the CA MTUS for topical use. Regarding topical gabapentin, Chronic Pain Medical Treatment Guidelines state that topical anti-epileptic medications are not recommended. They go on to state that there is no peer-reviewed literature to support their use. Tramadol is not supported in topical form. As such, the currently requested Topical cream, Capsaicin 0.0375%, Tramadol 8%, Cyclobenzaprine 4%, Menthol 5%, Gabapentin 10% 180gms times 1 is not medically necessary.

Urine drug screen: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R Page(s): 76-79 and 99 of 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chronic Pain Chapter Urine Drug Testing.

Decision rationale: Regarding the request for a repeat urine toxicology test (UDS), CA MTUS Chronic Pain Medical Treatment Guidelines state the drug testing is recommended as an option. Guidelines go on to recommend monitoring for the occurrence of any potentially aberrant (or non-adherent) drug related behaviors. ODG recommends urine drug testing on a yearly basis for low risk patients, 2-3 times a year for moderate risk patients, and possibly once per month for high risk patients. Within the documentation available for review, it is unclear whether the patient is taking controlled substance medication. The patient recently underwent a urine drug screen. There is no documentation of risk stratification to identify the medical necessity of drug screening at the proposed frequency. Additionally, there is no documentation that the physician is concerned about the patient misusing or abusing any controlled substances. In light of the above issues, the currently requested repeat urine toxicology test is not medically necessary.

Interferential stimulator home unit for chronic pain times 60 day trial: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R Page(s): 118-120 of 127.

Decision rationale: Regarding the request for interferential unit, CA MTUS Chronic Pain Medical Treatment Guidelines state that interferential current stimulation is not recommended as an isolated intervention. They go on to state that patient selection criteria if interferential stimulation is to be used anyways include pain is ineffectively controlled due to diminished effectiveness of medication, side effects or history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercises, or unresponsive to conservative treatment. If those criteria are met, then in one month trial may be appropriate to study the effects and benefits. With identification of objective functional improvement, additional interferential unit use may be supported. Within the documentation available for review, there is no indication that the patient has met the selection criteria for interferential stimulation (pain is ineffectively controlled due to diminished effectiveness of medication, side effects or history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercises, or unresponsive to conservative treatment). Additionally, guidelines recommend a 30-day trial, and there is no provision to modify the currently requested 60-day trial. In light of the above issues, the currently requested interferential unit is not medically necessary.