

Case Number:	CM15-0011362		
Date Assigned:	02/20/2015	Date of Injury:	08/02/2013
Decision Date:	04/07/2015	UR Denial Date:	01/02/2015
Priority:	Standard	Application Received:	01/20/2015

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: Ohio, North Carolina, Virginia
Certification(s)/Specialty: Family Practice

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 45-year-old male, who sustained an industrial injury on 04/05/2013. The diagnoses have included cervical sprain, lumbar sprain, bilateral shoulder sprain, anxiety/depression, and abdominal pain. Noted treatments to date have included shockwave therapy and meds. No MRI report noted in received medical records. In a progress note dated 10/10/2014, the injured worker presented with complaints of cervical and lumbar spine pain, bilateral shoulder pain, and generalized abdominal pain. The treating physician reported limited range of motion to cervical and lumbar spine. Utilization Review determination on 01/02/2015 non-certified the request for Dextromethorphan 5%/Gabapentin 5%/Bupivacaine 2.5%/Menthol 1%/Camphor 1% 210gm, 6 Sessions Chiropractic treatment 2 times a week for 3 weeks, Shoulder, 8 Sessions Chiropractic treatment 2 times a week for 4 weeks, Neck, Localized Intense Neurostimulation Therapy (LINT), Psychological Evaluation, Flurbiprofen 10%/Baclofen 5%/Dexamethasone 1% 210gm, CYP 450 Pharmacological Assay, and Trigger Points Impedance Imaging citing Medical Treatment Utilization Schedule Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Compounded medication (Dextromethorphan 5%/ Gabapentin 5%/ Bupivacaine 2.5%/ Menthol 1%/ Camphor 1%) 210gm: 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 Topical analgesics Page(s): 111-113.

Decision rationale: The CA MTUS states that any compound that contains one non-recommended ingredient is not recommended in its entirety. Topical gabapentin is not recommended by the guidelines. Consequently, Compounded medication (Dextromethorphan 5%/ Gabapentin 5%/ Bupivacaine 2.5%/ Menthol 1%/ Camphor 1%) 210gm is not medically necessary.

Chiropractic treatment 2 x wk x 3 wks for shoulder: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines. Shoulder chapter. Manipulation section.

Decision rationale: There is limited evidence to specifically support the utilization of manipulative procedures of the shoulder, but this procedure is routinely applied by chiropractic providers whose scope allows it, and the success of chiropractic manipulation for this may be highly dependent on the patient's previous successful experience with a chiropractor. In general, it would not be advisable to use this modality beyond 2-3 visits if signs of objective progress towards functional restoration are not demonstrated. A recent clinical trial concluded that manipulative therapy for the shoulder girdle in addition to usual medical care accelerates recovery of shoulder symptoms. There is fair evidence for the treatment of a variety of common rotator cuff disorders, shoulder disorders, adhesive capsulitis, and soft tissue disorders using manual and manipulative therapy (MMT) to the shoulder, shoulder girdle, and/or the full kinetic chain combined with or without exercise and/or multimodal therapy. In this instance, it is evident that the injured worker has had chiropractic treatment of the left shoulder previously for his diagnoses of rotator cuff tendonitis and AC joint osteoarthritis. Previous chiropractic notes have not been included for review. Therapy notes from extracorporeal shockwave therapy indicate as much but also note that significant residual symptoms remained. Because it is evident that previous shoulder chiropractic sessions have occurred without documentation of progress towards functional restoration, chiropractic treatment 2 x wk x 3 wks for shoulder is not medically necessary.

Chiropractic treatment 2 x wk x 4 wks for neck: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines. Neck and Upper Back chapter. Manipulation section.

Decision rationale: In limited existing trials, cervical manipulation has fared equivocally with other treatments, like mobilization, and may be a viable option for patients with mechanical neck disorders. However, it would not be advisable to use beyond 2-3 weeks if signs of objective progress towards functional restoration are not demonstrated. In this instance, treatment notes from extracorporeal shockwave treatment sessions indicate that chiropractic treatments have occurred but that significant residuals remain. No other chiropractic notes have been provided. Because it seems that previous chiropractic treatment has occurred without obvious progress towards functional restoration, chiropractic treatment 2 x wk x 4 wks for neck is not medically necessary.

Psychological Evaluation: Overturned

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 Psychological evaluations Page(s): 100.

Decision rationale: Psychological evaluations are generally accepted, well-established diagnostic procedures not only with selected use in pain problems, but also with more widespread use in chronic pain populations. Diagnostic evaluations should distinguish between conditions that are pre-existing, aggravated by the current injury or work related. Psychosocial evaluations should determine if further psychosocial interventions are indicated. In this instance, it seems that the injured worker has had previous biofeedback treatment. He does have chronic pain with delayed recovery. Consequently, a psychological evaluation is medically necessary.

Compounded medication (Flurbiprofen 10%/ Baclofen 5%/ Dexamethasone 1%) 210gm: 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 Topical analgesics Page(s): 111-113.

Decision rationale: The CA MTUS states that compounds containing one non-recommended ingredient are not recommended in its entirety. Baclofen: Not recommended. There is currently one Phase III study of Baclofen-Amitriptyline- Ketamine gel in cancer patients for treatment of chemotherapy-induced peripheral neuropathy. There is no peer-reviewed literature to support the use of topical baclofen. Because the requested compound contains baclofen, the compounded medication (Flurbiprofen 10%/ Baclofen 5%/ Dexamethasone 1%) 210gm is not medically necessary.

CYP 450 Pharmacological Assay: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines. Pain (Chronic) chapter. Pharmacogenetic testing/ pharmacogenomics (opioids & chronic non-malignant pain).

Decision rationale: Cytochrome P450 enzymes are responsible for about 80% of phase I metabolism of codeine, hydrocodone, oxycodone, tramadol, fentanyl and methadone. The three major groups responsible are CYP2D6, CYP3A, and CYP2C. Opioids that are unaffected or only mildly affected by CYP 450 include morphine, hydromorphone, oxymorphone, and tapentadol. The latter primarily use glucuronidation for metabolism. Most opioids act without biotransformation at the opioid receptor and provide pain relief without being metabolized in first-pass effect. Testing is not recommended except in a research setting. In many complex trials evaluating the effect of opioids on pain, population-based genetic association studies have had mixed success and reproducibility has been poor. Evidence is not yet sufficiently robust to determine association of pain-related genotypes and variability in opioid analgesia in human studies. There are currently multiple challenges in using this technique in the context of pain: (1) the phenotypes involved are multifaceted; (2) pain perception has a subjective nature; (3) response to analgesia can also be subjective; (4) there is a wide inter-individual pharmacologic range in response to drugs. The range in which genetic factors are thought to play a role in pain perception is from 12% to 60%. Gender and age also play a role. There are no published guidelines for generalized testing of the cytochrome system outside of certain populations (specific cancers, patients requiring anticoagulation, and human immunodeficiency virus patients). There has been some suggestion that testing should be undertaken in patients who are on high dose opioids (morphine equivalent dose-150 mg/day). Recent opioid guidelines, including the ODG do not recommend opioids greater than this dose, and there are no randomized controlled trials to support this. In addition, most opioids can be adequately titrated in clinical practice. In this instance, the medical record reflects that the opioid in use is Tramadol. Because the dose of prescribed opioids does not appear to exceed 120 morphine equivalents per day, CYP 450 pharmacological assay is not medically necessary.

Trigger point impedance imaging: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines. Pain (Chronic) chapter. Hyperstimulation analgesia section.

Decision rationale: Not recommended until there are higher quality studies. Initial results are promising, but only from two low quality studies sponsored by the manufacturer (Nervomatrix

Ltd., Netanya, Israel). Localized manual high-intensity neurostimulation devices are applied to small surface areas to stimulate peripheral nerve endings (A fibers), thus causing the release of endogenous endorphins. This procedure, usually described as hyperstimulation analgesia, has been investigated in several controlled studies. However, such treatments are time consuming and cumbersome, and require previous knowledge of the localization of peripheral nerve endings responsible for LBP or manual impedance mapping of the back, and these limitations prevent their extensive utilization. The new device is capable of automatically measuring skin impedance in a selected body area and, immediately afterwards, of stimulating multiple points that are targeted according to differentiation in their electrical properties and proprietary image processing algorithms with high intensity yet non-painful electrical stimulation. The therapeutic neurostimulation pulse modulation of dense electrical pulses is applied locally to specific Active Trigger Points (ATPs) which are locations of nerve ending associated with pain, providing effective pain relief by stimulating the release of endorphins, the body's natural pain killers. The gate control theory of pain describes the modulation of sensory nerve impulses by inhibitory mechanisms in the central nervous system. One of the oldest methods of pain relief is generalized hyperstimulation analgesia produced by stimulating myofascial trigger points by dry needling, acupuncture, intense cold, intense heat, or chemical irritation of the skin. The moderate-to-intense sensory input of hyperstimulation analgesia is applied to sites over or sometimes distant from, the pain. A brief painful stimulus may relieve chronic pain for long periods, sometimes permanently. The new device takes advantage of these same principles. Hyperstimulation analgesia with localized, intense, low-rate electrical pulses applied to painful active myofascial trigger points was found to be effective in 95% patients with chronic nonspecific low back pain, in a clinical validation study. LINT is a form of hyperstimulation analgesia. Hyperstimulation analgesia is not recommended by the referenced guidelines. Therefore, trigger point impedance imaging, which is used to target hyperstimulation analgesia, is not medically necessary.

Localized intense neurostimulation therapy (LINT) (unspecified body part): Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines. Pain (Chronic) chapter. Hyperstimulation analgesia section.

Decision rationale: Not recommended until there are higher quality studies. Initial results are promising, but only from two low quality studies sponsored by the manufacturer (Nervomatrix Ltd., Netanya, Israel). Localized manual high-intensity neurostimulation devices are applied to small surface areas to stimulate peripheral nerve endings (A fibers), thus causing the release of endogenous endorphins. This procedure, usually described as hyperstimulation analgesia, has been investigated in several controlled studies. However, such treatments are time consuming and cumbersome, and require previous knowledge of the localization of peripheral nerve endings responsible for LBP or manual impedance mapping of the back, and these limitations prevent their extensive utilization. The new device is capable of automatically measuring skin impedance in a selected body area and, immediately afterwards, of stimulating multiple points that are

targeted according to differentiation in their electrical properties and proprietary image processing algorithms with high intensity yet nonpainful electrical stimulation. The therapeutic neurostimulation pulse modulation of dense electrical pulses is applied locally to specific Active Trigger Points (ATPs) which are locations of nerve ending associated with pain, providing effective pain relief by stimulating the release of endorphins, the body's natural pain killers. The gate control theory of pain describes the modulation of sensory nerve impulses by inhibitory mechanisms in the central nervous system. One of the oldest methods of pain relief is generalized hyperstimulation analgesia produced by stimulating myofascial trigger points by dry needling, acupuncture, intense cold, intense heat, or chemical irritation of the skin. The moderate-to-intense sensory input of hyperstimulation analgesia is applied to sites over or sometimes distant from, the pain. A brief painful stimulus may relieve chronic pain for long periods, sometimes permanently. The new device takes advantage of these same principles. Hyperstimulation analgesia with localized, intense, low-rate electrical pulses applied to painful active myofascial trigger points was found to be effective in 95% patients with chronic nonspecific low back pain, in a clinical validation study. In this instance, hyperstimulation analgesia is not currently recommended by the referenced guidelines. LINT therapy is a form of hyperstimulation analgesia. Therefore, localized intense neurostimulation therapy (LINT) (unspecified body part) is not medically necessary.