

Case Number:	CM15-0161276		
Date Assigned:	09/02/2015	Date of Injury:	06/25/2009
Decision Date:	10/21/2015	UR Denial Date:	08/11/2015
Priority:	Standard	Application Received:	08/18/2015

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 was a 48 year old male, who sustained an industrial injury, June 25, 2014. The injured worker previously received the following treatments thoracic spine MRI, lumbar spine MRI, cervical spine MRI, brain MRI, abdominal and pelvis CT scan, right shoulder surgery times 2, Tramadol, TENS (transcutaneous electrical nerve stimulator) unit, EMG and NCS (electrodiagnostic studies and nerve conduction studies) of the bilateral upper extremities, random toxicology laboratory studies, failed right shoulder surgery time 2, Hydrocodone, Cyclobenzaprine, activity modification, stretching, heat, physical therapy and home exercise program. The injured worker was diagnosed with bilateral carpal tunnel syndrome; status post right shoulder rotator cuff repair, persistent impingement and possible recurrent rotator cuff tear and right knee, status post bilateral total knee replacement and headaches. According to progress note of June 11, 2015, the injured worker's chief complaint was right shoulder, right wrist right hand, left wrist, left hand, right knee, left knee and headaches. The physical exam noted tenderness of the right shoulder. The incision was well healed. The Tinel's and Phalen's test was positive bilaterally. There was diminished sensation of the medial nerve distribution bilaterally. The Jamar test on the left and right was no greater than 5 pounds on 3 attempts. There was tenderness of bilateral knees. The incisions were well healed. The range of motion was 0-90 degrees. The injured worker had difficulty arising from a seated position. The treatment plan included toxicology testing, right wrist MRI, Left wrist MRI, compound cream, chiropractic for the right wrist, right hand and right shoulder, Zolpidem, Norco and ESWT. A urine drug screen performed on January 21, 2015 was negative for all substances including hydrocodone which is listed as prescribed. An electrodiagnostic study dated March 9, 2015 is normal.

IMR ISSUES, DECISIONS AND RATIONALES

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

Toxicology testing: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids (Classification), Opioids, California Controlled Substance Utilization Review and Evaluation System (CURES) [DWC], Opioids, criteria for use, Opioids for chronic pain, Opioids for neuropathic pain, Opioids for osteoarthritis, Opioids, cancer pain vs. nonmalignant pain, Opioids, dealing with misuse & addiction, Opioids, differentiation: dependence & addiction, Opioids, dosing, Opioids, indicators for addiction, Opioids, long-term assessment. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Urine Drug Testing.

Decision rationale: Regarding the request for a 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 appears the patient is on controlled substance medication. Additionally, there is no identification of a recent urine drug screen. Additionally, it appears the patient had an inconsistent urine drug screen 10 months ago. Repeating that examination would be reasonable to reduce the risk of misuse, abuse, and diversion. As such, the currently requested urine toxicology test is medically necessary.

MRI of the right wrist: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, MRI Wrists.

MAXIMUS guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, and Hand Chapter, Other Diagnoses.

Decision rationale: Regarding the request for MRI of the right wrist, California MTUS and ACOEM note that imaging studies to clarify the diagnosis may be warranted if the medical history and physical examination suggest specific disorders. More specifically, ODG notes that MRIs for carpal tunnel syndrome are not recommended in the absence of ambiguous electrodiagnostic studies. In general, they are supported in chronic wrist pain if plain films are normal and there is suspicion of a soft tissue tumor or Kienbock's disease. Within the documentation available for review, there is no clear indication of a condition for which an MRI is supported as noted above or another clear rationale for the use of MRI in this patient. Additionally, no physical exam findings suggesting serious pathology have been identified. In the absence of such documentation, the currently requested MRI of the right wrist is not medically necessary.

MRI of the left wrist: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, MRI Wrists.

MAXIMUS guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, and Hand and Carpal Tunnel Syndrome Chapters.

Decision rationale: Regarding the request for MRI of the left wrist, California MTUS and ACOEM note that imaging studies to clarify the diagnosis may be warranted if the medical history and physical examination suggest specific disorders. More specifically, ODG notes that MRIs for carpal tunnel syndrome are not recommended in the absence of ambiguous electrodiagnostic studies. In general, they are supported in chronic wrist pain if plain films are normal and there is suspicion of a soft tissue tumor or Kienbock's disease. Within the documentation available for review, there is no clear indication of a condition for which an MRI is supported as noted above or another clear rationale for the use of MRI in this patient. Additionally, no physical exam findings suggesting serious pathology have been identified. In the absence of such documentation, the currently requested MRI of the left wrist is not medically necessary.

Retrospective: Flurbiprofen 20%/Baclofen 5%/Camphor 2%/Menthol 2%/Dexamethasone Micro 0.2%/Capsaicin 0.025%/Hyaluronic Acid 0.2% cream base 250 gm (DOS unknown): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation ODG, Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: Regarding the request for Flurbiprofen 20%/Baclofen 5%/Camphor 2%/Menthol 2%/Dexamethasone Micro 0.2%/Capsaicin 0.025%/Hyaluronic Acid 0.2% cream base 250 gm, 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. Guidelines do not support the use of topical Hyaluronic acid. As such, the currently requested Flurbiprofen 20%/Baclofen 5%/Camphor 2%/Menthol 2%/Dexamethasone Micro 0.2%/Capsaicin 0.025%/Hyaluronic Acid 0.2% cream base 250 gm is not medically necessary.

Retrospective: Amitriptyline 10%/Gabapentin 10%/Bupivacaine 5%/Hyaluronic Acid 0.2% cream base 250 gm (DOS unknown): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation ODG, Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: Regarding the request for Amitriptyline 10%/Gabapentin 10%/Bupivacaine 5%/Hyaluronic Acid 0.2% cream base 250 gm (DOS unknown), CA MTUS states that topical compound medications require guideline support for all components of the compound in order for the compound to be approved. Guidelines do not support the use of topical antidepressants. 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. Guidelines do not support the use of topical Hyaluronic Acid. As such, the currently requested Amitriptyline 10%/Gabapentin 10%/Bupivacaine 5%/Hyaluronic Acid 0.2% cream base 250 gm (DOS unknown) is not medically necessary.

Chiropractic physiotherapy for the right shoulder, 6 visits: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

Decision rationale: Regarding the request for Chiropractic physiotherapy - right shoulder, 6 visits, Chronic Pain Medical Treatment Guidelines support the use of chiropractic care for the treatment of chronic pain caused by musculoskeletal conditions. Guidelines go on to recommend a trial of up to 6 visits over 2 weeks for the treatment of low back pain. With evidence of objective functional improvement, a total of up to 18 visits over 6 to 8 weeks may be supported. Within the documentation available for review, it is unclear exactly what objective functional deficits are intended to be addressed with the currently requested chiropractic care. Additionally, if the patient has undergone chiropractic care before, there is no documentation of objective functional improvement from the sessions. Furthermore, it is unclear how many therapy sessions the patient has already undergone making it impossible to determine if the patient has exceeded the maximum number recommended by guidelines for their diagnosis. In the absence of clarity regarding the above issues, the currently requested Chiropractic physiotherapy - right shoulder, 6 visits is not medically necessary.

Chiropractic physiotherapy for the bilateral wrist/hand, 6 visits: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

Decision rationale: Regarding the request for Chiropractic physiotherapy - bilateral wrist/hand, 6 visits, Chronic Pain Medical Treatment Guidelines support the use of chiropractic care for the treatment of chronic pain caused by musculoskeletal conditions. Guidelines go on to recommend a trial of up to 6 visits over 2 weeks for the treatment of low back pain. With evidence of objective functional improvement, a total of up to 18 visits over 6 to 8 weeks may be supported. Guidelines state that it is not recommended for the forearm, wrist, or hand. As such, the currently requested Chiropractic physiotherapy - bilateral wrist/hand, 6 visits is not medically necessary.

Retrospective: Zolpidem 10mg #30 (DOS unknown): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain, Sleep Medication, Insomnia treatment.

Decision rationale: Regarding the request for zolpidem (Ambien), California MTUS guidelines are silent regarding the use of sedative hypnotic agents. ODG recommends the short-term use (usually two to six weeks) of pharmacological agents only after careful evaluation of potential causes of sleep disturbance. They go on to state the failure of sleep disturbances to resolve in 7 to 10 days, may indicate a psychiatric or medical illness. Within the documentation available for review, there is no current description of the patient's insomnia, no discussion regarding what behavioral treatments have been attempted, and no statement indicating how the patient has responded to Ambien treatment. Furthermore, there is no indication that Ambien is being used for short term use as recommended by guidelines. In the absence of such documentation, the currently requested zolpidem (Ambien) is not medically necessary.

Norco 10/325mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids (Classification).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids (Classification), Opioids, California Controlled Substance Utilization Review and Evaluation System (CURES) [DWC], Opioids, criteria for use, Opioids for chronic pain, Opioids for neuropathic pain, Opioids for osteoarthritis, Opioids, cancer pain vs. nonmalignant pain, Opioids, dealing with misuse & addiction, Opioids, differentiation: dependence & addiction, Opioids, dosing, Opioids, indicators for addiction, Opioids, long-term assessment.

Decision rationale: Regarding the request for Norco (hydrocodone/acetaminophen), California Pain Medical Treatment Guidelines state that this is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no indication that the medication is improving the patient's function or pain (in terms of specific examples of functional improvement and percent reduction in pain or reduced NRS), no documentation regarding side effects, and no discussion regarding aberrant use. As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested Norco (hydrocodone/acetaminophen) is not medically necessary.

Extracorporeal shock wave therapy: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, ESWT to Shoulder.

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Initial Care. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Extracorporeal Shockwave Therapy (ESWT) and Other Medical Treatment Guidelines x Other Medical Treatment Guideline or Medical Evidence: Anthem Medical Policy # SURG.00045 Extracorporeal Shock Wave Therapy for Orthopedic Conditions.

Decision rationale: Regarding the request for extracorporeal shockwave therapy, It is unclear which body part this treatment modality is intended for. Occupational Medicine Practice Guidelines support the use of extracorporeal shock wave therapy for calcified tendinitis of the shoulder. ODG further clarifies that extracorporeal shockwave therapy is recommended for calcified tendinitis of the shoulder but not for other shouldered disorders. ODG does not address the issue for the wrists. Anthem medical policy notes that ESWT for the treatment of musculoskeletal conditions is considered investigational and not medically necessary. Within the documentation available for review, there is no identification of a diagnosis of calcified tendinitis, and no support for this modality for any other effected body parts. As such, the currently requested extracorporeal shock wave therapy is not medically necessary.