

Case Number:	CM15-0169067		
Date Assigned:	09/09/2015	Date of Injury:	03/23/2015
Decision Date:	10/28/2015	UR Denial Date:	08/24/2015
Priority:	Standard	Application Received:	08/27/2015

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: Tennessee, Florida, Ohio
 Certification(s)/Specialty: Surgery, Surgical Critical Care

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This injured worker is a 41 year old male, who sustained an industrial injury on 03-23-2015 secondary to receiving blunt trauma to the face. The injured worker was diagnosed as having headache, cervical disc displacement, cervical muscle spasms, and cervical sprain-strain. On medical records dated 03-26-2015, 05-18-2015 and 08-11-2015, the subjective findings noted frequent headaches associated blurred and double vision, nausea, dizziness, ringing in ears, loss of equilibrium, memory problem, problems focusing and difficulty sleeping. Pain level was noted as a 9 out of 10 and the lowest pain being a 1 and maximum pain level being a 10. Neck pain was noted with radiation to the bilateral upper extremity. Frequent upper and mid back pain was noted as well. Lumbar spine pain with radiating pain to left lower extremity, this pain was noted to associate with numbness and weakness, tingling and burning sensation. Right and left shoulder, right wrist, left and right knee intermittent pain was noted as well. Objective findings were noted as having a mild antalgic gait and a limp. Cervical spine revealed tenderness to palpation to paravertebral muscles. Muscle spasms of the cervical paravertebral muscles were noted. Thoracic spine was noted to have tenderness and spasm to palpation in the paravertebral muscles as well. Tenderness was noted at the right volar wrist, and anterior right and left knee. The injured worker was noted not to be working. The injured worker underwent laboratory studies and diagnostic testing. Treatment to date included medication. Current medication included Flexeril, Vicodin and Topiramate. The Utilization Review (UR) dated 08-24-2015, was noted to have a Request for Authorization dated 08-11-2015. The UR submitted for this medical review indicated that the request for extracorporeal shockwave therapy was non-certified, trigger

points impedance imaging was non-certified, localized intense neurostimulation therapy was non-certified, Norco 10-325mg #60 was modified, Cyclobenzaprine 10mg#30 was modified and MRI of the bilateral temporomandibular joint was non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Extracorporeal shockwave therapy: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Initial Care, Special Studies.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this request for this patient. The MTUS Chronic Pain Guidelines do not address the topic of shockwave therapy. ACOEM Guidelines state, "There is no high-grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction, heat/cold applications, massage, diathermy, cutaneous laser treatment, ultrasound, transcutaneous electrical neurostimulation (TENS) units, and biofeedback. These palliative tools may be used on a trial basis but should be monitored closely." The Official Disability Guidelines note extracorporeal shock wave therapy is recommended for patients whose pain from calcifying tendinitis of the shoulder has remained despite six months of standard treatment. Within the provided documentation, the Guidelines recommend the use of shockwave treatment for the shoulder; however, there are no indications for use in the cervical spine. Within the provided documentation, the requesting physician did not include an adequate and complete assessment of the patient's current objective functional condition in order to demonstrate functional deficits needing to be addressed with the specifically requested treatment. Additionally, the requesting physician's rationale for the request was unclear. Therefore, based on the submitted medical documentation, the request for extracorporeal shockwave therapy is not medically necessary.

Trigger points impedance imaging: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Pain, Hyperstimulation Therapy.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this request for this patient. The California MTUS guidelines and the ACOEM Guidelines do not address this topic. According to the available records, the rationale for the trigger point imaging was to follow with LINT therapy. MTUS does not require trigger point impedance imaging to locate a trigger point. MTUS criteria require palpation with twitch response. The trigger point imaging is not necessary for LINT for the lower back, because the

Occupational Disability Guidelines specifically states this therapy is not recommended for the lumbar spine. Hence, this request is not in accordance with MTUS guidelines to locate trigger points. Therefore, based on the submitted medical documentation, the request for trigger point impedance imaging is not medically necessary.

Localized intense neurostimulation therapy: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pain Research And Treatment, Research Article, A Novel, Image, Guided Automatic, High, Intensity Neurostimulation Device For The Treatment Of Non-specific Low Back Pain, Gorenberg, Et Al, pain Research And Treatment, Research Article, A Novel, Image, Guided Automatic, High Intensity Neurostimulation Device For The Treatment Of Non-specific Low Back Pain, Gorenberg, Et Al.

Decision rationale: Based on the description of the modality in question, localized intense neurostimulation therapy appears to represent a form of percutaneous electrical neurostimulation (PENS) therapy. As noted on page 97 of the MTUS Chronic Pain Medical Treatment Guidelines, PENS are not recommended as a primary treatment modality but can be considered on a trial basis if used as an adjunct to a program of evidence based functional restoration, after other nonsurgical options such as therapeutic exercise and TENS have been tried and/or failed. In this case, however, there is no clear evidence that the employee has tried and failed conventional TENS unit. There is no evidence that the employee is intent on functional restoration. Finally, there is no evidence that the employee is intent on using the proposed LINT therapy as an adjunct to functional restoration and exercise. Therefore, based on the submitted medical documentation, the request for intense neurostimulation therapy is not medically necessary.

Norco 10/325 mg, sixty count: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids for chronic pain, Opioids, long-term assessment.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this prescription for this patient. In accordance with California MTUS guidelines, narcotics for chronic pain management should be continued if "(a) If the patient has returned to work, (b) If the patient has improved functioning and pain." MTUS guidelines also recommends that dosing "not exceed 120 mg oral morphine equivalents per day, and for patients taking more than one opioid, the morphine equivalent doses of the different opioids must be added together to determine the cumulative dose." 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 pain (in terms of percent reduction in pain or reduced NRS), no documentation regarding side effects, and no discussion regarding aberrant use. Therefore, based on the submitted medical documentation, the request for Norco 10/325 is not medically necessary.

Cyclobenzaprine 10 mg, thirty count: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this prescription for this patient. In accordance with the California MTUS guidelines, Cyclobenzaprine is a muscle relaxant and muscle relaxants are not recommended for the treatment of chronic pain. From the MTUS guidelines: "Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic back pain". Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. This patient has been diagnosed with chronic back pain of the cervical and upper spine. Per MTUS, the use of a muscle relaxant is not indicated. Therefore, based on the submitted medical documentation, the request for Cyclobenzaprine is not medically necessary.

MRI of the bilateral temporomandibular joint: 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 Natl J Maxillofac Surg. 2012 Jan;3(1):2-9. doi: 10.4103/0975-5950.102138. Efficacy of plain radiographs, CT scan, MRI and ultrasonography in temporomandibular joint disorders. Sinha VP1, Pradhan H, Gupta H, Mohammad S, Singh RK, Mehrotra D, Pant MC, Pradhan R.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this request for this patient. The California MTUS guidelines, Occupational Disability Guidelines and the ACOEM Guidelines do not address this topic. Therefore, alternative sources were sought. Based on a recent publication in the National Journal of Maxillofacial surgery, TMJ MRI should be reserved for those who fail a minimum of 6 weeks of non-surgical treatment and who are actively being considered for TMJ surgery. Requests should come from a maxillofacial surgeon. In this patient's case, there is no current subjective or objective examination of the TMJ and there is no indication that TMJ surgery is being planned. There was no mention of any conservative treatment. Therefore, based on the submitted medical documentation, the request for MRI of bilateral TMJ is not medically necessary.

