

Case Number:	CM15-0184904		
Date Assigned:	09/25/2015	Date of Injury:	07/23/2002
Decision Date:	11/02/2015	UR Denial Date:	08/27/2015
Priority:	Standard	Application Received:	09/21/2015

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: Texas, Florida, California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 58 year old female with a date of injury on 07-23-2002. The injured worker is undergoing treatment for right shoulder impingement syndrome, right acromioclavicular cartilage disorder, right subacromial-subdeltoid bursitis, right bicipital tendinitis, cervicogenic headaches, cervicalgia, and thoracic spine sprain-strain. A physician note dated 03-20-2015 documents the injured worker is having an exacerbation of her pain with this visit with her headache pain is rated a 6 out of 10. She has neck pain that she rates as 5 out of 10 and it is burning, with numbness on the left side of her neck. Her upper extremity pain is rated 3-5 out of 10. She has a positive Neer's, positive 90 degree cross over impingement test, positive Apley's, positive Hawkins and weak abduction against resistance. Her lower back pain is rated 5 out of 10. A physician progress note dated 08-13-2015 documents the injured worker complains of cervical spine pain rated 7 out of 10 and it is sharp and achy. She complains of a headache and rates the pain as 6 out of 10. She has back pain rated 7 out of 10 with numbness, tingling, burning and muscle spasms. She has bilateral upper extremity pain that has been 6 out of 10 for the last several weeks, but today it is 0 out of 10. Cervical spine range of motion is restricted with pain noted at all endpoints. She has full range of motion in her bilateral upper extremities and no complaint of pain. Lumbar spine range of motion is restricted. She uses a quad cane with ambulation. She has paraspinal tenderness to palpation. Treatment to date has included diagnostic studies, medications, and chiropractic sessions. Treatment plan includes Amitriptyline 25mg (since at least 03-20-2015) #30 with 5 refills, a Transcutaneous Electrical Nerve Stimulation unit, and Tylenol 500mg (since at least 03-20-2015) #90 with 5 refills. On 08-27-2015 Utilization Review modified the request for Amitriptyline 25 mg #30 with 5 refills to Amitriptyline 25mg #30 with no refills. The request for a TENS unit was non-certified. Tylenol 500 mg #90 with 5 refills was modified to Tylenol 500mg #90 with no refills.

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 Chronic Pain Medical Treatment 2009.

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

Decision rationale: Chronic Pain Medical Treatment Guidelines: 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009), page 116 of 127. This claimant was injured in 2002 with shoulder and neck issues. There is headache pain as well. Cervical range of motion is limited. The outcomes of a TENS trial is not noted. The MTUS notes that TENS is not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration, for the conditions described below. Neuropathic pain: Some evidence (Chong, 2003), including diabetic neuropathy (Spruce, 2002) and post-herpetic neuralgia. (Niv, 2005) Phantom limb pain and CRPS II: Some evidence to support use. (Finsen, 1988) (Lundeberg, 1985) Spasticity: TENS may be a supplement to medical treatment in the management of spasticity in spinal cord injury. (Aydin, 2005) Multiple sclerosis (MS): While TENS does not appear to be effective in reducing spasticity in MS patients it may be useful in treating MS patients with pain and muscle spasm. (Miller, 2007) I did not find in these records that the claimant had these conditions that warranted TENS. Also, an outright purchase is not supported, but a monitored one month trial, to insure there is objective, functional improvement. In the trial, there must be documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; rental would be preferred over purchase during this trial. There was no evidence of such in these records. The request is appropriately not medically necessary.

Tylenol 500 mg #90 with 5 refills: 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): NSAIDs (non-steroidal anti-inflammatory drugs).

Decision rationale: Chronic Pain Medical Treatment Guidelines: Pain interventions and treatments, 8 C.C.R. 9792.20 - 9792.26, Page 60 and 67 of 127. This claimant was injured in 2002 with shoulder and neck issues. There is headache pain as well. Cervical range of motion is limited. The MTUS recommends NSAID medication for osteoarthritis and pain at the lowest

dose, and the shortest period possible. The guides cite that there is no reason to recommend one drug in this class over another based on efficacy. Further, the MTUS cites there is no evidence of long-term effectiveness for pain or function. This claimant though has been on some form of a prescription non-steroidal anti-inflammatory medicine for some time, with no documented objective benefit or functional improvement. The MTUS guideline of the shortest possible period of use is clearly not met. Without evidence of objective, functional benefit, such as improved work ability, improved activities of daily living, or other medicine reduction, the MTUS does not support the use of this medicine. The medicine is appropriately not medically necessary.

Amitriptyline 25 mg #30 with 5 refills: 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) Pain chapter, under Antidepressants.

Decision rationale: This claimant was injured in 2002 with shoulder and neck issues. There is headache pain as well. Cervical range of motion is limited. The objective, functional improvement outcomes out of a TENS trial is not noted. The current California web-based MTUS collection was reviewed in addressing this request. The guidelines are silent in regards to this request. Therefore, in accordance with state regulation, other evidence-based or mainstream peer-reviewed guidelines will be examined. Regarding antidepressants to treat a major depressive disorder, the ODG notes: Recommended for initial treatment of presentations of Major Depressive Disorder (MDD) that are moderate, severe, or psychotic, unless electroconvulsive therapy is part of the treatment plan. Not recommended for mild symptoms. In this case, it is not clear what objective benefit has been achieved out of the antidepressant usage, how the activities of daily living have improved, and what other benefits have been. It is not clear if this claimant has a major depressive disorder as defined in DSM-IV. If used for pain, it is not clear what objective, functional benefit has been achieved. The request is appropriately not medically necessary.