

Case Number:	CM15-0051307		
Date Assigned:	03/24/2015	Date of Injury:	06/29/2010
Decision Date:	05/13/2015	UR Denial Date:	03/04/2015
Priority:	Standard	Application Received:	03/18/2015

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, Washington

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 51-year-old male who reported an injury on 06/29/2010, with an unknown mechanism of injury. Current diagnoses include cervical degenerative disc disease, lumbar degenerative disc disease, cervical radiculitis, and shoulder strain. Treatment to date has included medications, diagnostics, electrodiagnostics, TENS unit, gym membership, and home exercise program. The clinical note dated 01/20/2015 indicates the patient was seen with complaints of pain in the neck, shoulder, and lower back. The physical examination revealed that the patient had a normal gait. The current request is for Percocet, trazodone, retrospective Lidopro cream, and therapeutic ultrasounds of the cervical spine, lumbar spine, and left shoulder.

IMR ISSUES, DECISIONS AND RATIONALES

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

Percocet 5/325mg Qty: 60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-94.

Decision rationale: The California MTUS Guidelines recommend continued use of this opioid for the treatment of moderate to severe pain, with documented objective evidence of functional benefits. The clinical documentation showed no evidence of documentation of pain relief, or functional benefits provided from the use of this medication. Given the above, this request is not medically necessary.

Trazodone 50mg Qty: 30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-depressants Page(s): 13-16.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antidepressants for chronic pain Page(s): 14-16.

Decision rationale: The California MTUS Guidelines recommend antidepressant treatment for chronic pain and neuropathic pain. However, there is also no documentation regarding any pain relief, or functional improvements with the use of this medication. As such, this request is not medically necessary.

Retrospective (DOS: 02/19/15) LidoPro Cream 121gm Qty: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Compound topical analgesic creams.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113.

Decision rationale: The California MTUS Guidelines do not recommend compound topical analgesic creams as they are considered highly experimental without proven efficacy and are only recommended for the treatment of neuropathic pain after failed first line therapy of antidepressants and anticonvulsants. The clinical documentation shows no indication that the patient has previously tried and failed antidepressants or anticonvulsants. As such, this request is not medically necessary.

Therapeutic Ultrasound of Cervical Spine Qty: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ultrasound, therapeutic Page(s): 123.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ultrasound, therapeutic Page(s): 123.

Decision rationale: The California MTUS Guidelines do not recommend therapeutic ultrasounds and note that the effectiveness of ultrasounds for treating people with pain,

musculoskeletal injuries, and soft tissue lesions remains questionable. Given the above, this request is not medically necessary.

Therapeutic Ultrasound of Lumbar Spine Qty: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ultrasound, therapeutic Page(s): 123.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ultrasound, therapeutic Page(s): 123.

Decision rationale: The California MTUS Guidelines do not recommend therapeutic ultrasounds and note that the effectiveness of ultrasounds for treating people with pain, musculoskeletal injuries, and soft tissue lesions remains questionable. Given the above, this request is not medically necessary.

Therapeutic Ultrasound of Left Shoulder Qty: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ultrasound, therapeutic Page(s): 123.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ultrasound, therapeutic Page(s): 123.

Decision rationale: The California MTUS Guidelines do not recommend therapeutic ultrasounds and note that the effectiveness of ultrasounds for treating people with pain, musculoskeletal injuries, and soft tissue lesions remains questionable. Given the above, this request is not medically necessary.