

Case Number:	CM15-0081044		
Date Assigned:	05/05/2015	Date of Injury:	06/25/2012
Decision Date:	09/09/2015	UR Denial Date:	03/23/2015
Priority:	Standard	Application Received:	04/27/2015

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: New York

Certification(s)/Specialty: Internal 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 65-year-old male, who sustained an industrial injury on June 25, 2012. He reported left shoulder pain and low back pain. The injured worker was diagnosed as having left biceps tear, lumbosacral sprain/strain, lumbar spondylosis, and rule out lumbar spine disc protrusion, situational depression and sleep disruptions secondary to pain. Treatment to date has included shockwave therapy, epidural steroid injections, medications, physical therapy, back brace, cane for ambulation, activity restrictions and work restrictions. Currently, the injured worker complains of continued left shoulder pain and low back pain with pain radiating to the extremities, depression and sleep disruptions. The injured worker reported an industrial injury in 2012, resulting in the above noted pain. He was treated conservatively without complete resolution of the pain. Evaluation on March 31, 2015, revealed continued symptoms. A functional capacity evaluation, equipment and medications were requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Patient Education web class: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 398.

Decision rationale: Education is a cornerstone of effective treatment. Patients may find it therapeutic to understand the mechanism and natural history of the stress reaction and that it is a normal occurrence when their resources are overwhelmed. Education also provides the framework to encourage the patient to enhance his or her coping skills, both acutely and in a preventive manner by regularly using stress management techniques. Physicians, ancillary providers, support groups, and patient-appropriate literature are all education resources. The treating provider notes do not outline specific topics about this request. There is no information if such class was given to injured worker in the past and what was its outcome. Within the submitted medical records, the determination cannot be made. Therefore, the Requested Treatment: 1 Patient Education web class is not Medically necessary.

1 Functional Capacity Evaluation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, 2nd Edition Chapter 7 Independent Medical Examinations and Consultations; Official Disability Guidelines (ODG) Treatment in Workers' Compensation , Online Edition.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-90. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter--Work conditioning, work hardening.

Decision rationale: A number of functional assessment tools are available, including functional capacity exams and videotapes. Most assess general functioning, but modifications to test work-related functioning are under development or can be created by the clinician. ODG states valid Functional Capacity Evaluation (FCE) should be performed, administered and interpreted by a licensed medical professional. The results should indicate consistency with maximal effort, and demonstrate capacities below an employer verified physical demands analysis (PDA). Inconsistencies and/or indication that the patient has performed below maximal effort should be addressed prior to treatment in these programs. Within the medical information available for review, the injured worker has chronic pain and there is no indication the injured worker is close or at maximum-medical-improvement (MMI). There is no documentation of prior unsuccessful return-to-work (RTW) attempts. Medical records lack information about job description, physical demand level and specific work-related tasks. In addition, records do not document injured worker's return to work goals. The medical necessity of the requested service has not been medically necessary.

Extracorporeal shockwave therapy sessions for the left shoulder: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203.

Decision rationale: As per MTUS/ACOEM Physical modalities, such as massage, diathermy, cutaneous laser treatment, ultrasound treatment, transcutaneous electrical neurostimulation (TENS) units, and biofeedback are not supported by high-quality medical studies, but they may be useful in the initial conservative treatment of acute shoulder symptoms, depending on the experience of local physical therapists available for referral. Some medium quality evidence supports manual physical therapy, ultrasound, and high-energy extracorporeal shock wave therapy for calcifying tendinitis of the shoulder. Patients' at-home applications of heat or cold packs may be used before or after exercises and are as effective as those performed by a therapist are. Initial use of less-invasive techniques provides an opportunity for the clinician to monitor progress before referral to a specialist. Review of submitted Records indicates that injured worker is complaining of left shoulder pain and low back pain with pain radiating to the extremities, depression and sleep disruptions. As per progress notes in the Medical Records, the injured worker does not appear to have any significant changes in her chronic symptoms, and there is no evidence of calcifying tendinitis. The requested treatment for Extracorporeal shockwave therapy sessions for the left shoulder is not medically necessary and appropriate.

1 hot /cold therapy unit purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 12 Low Back Complaints. 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 Official Disability Guidelines (ODG) Knee and Leg Chapter--Cold/heat packs.

Decision rationale: ODG recommends Ice massage compared to control had a statistically beneficial effect on ROM, function and knee strength. Cold packs decreased swelling. Hot packs had no beneficial effect on edema compared with placebo or cold application. Ice packs did not affect pain significantly compared to control in patients with knee osteoarthritis. ODG states Continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. This meta-analysis showed that cryotherapy has a statistically significant benefit in postoperative pain control, while no improvement in postoperative range of motion or drainage was found. As the cryotherapy apparatus is inexpensive, easy to use, has a high level of patient satisfaction, and is rarely associated with adverse events, we believe that cryotherapy is justified in the postoperative management of surgery. Currently, the injured worker complains of continued left shoulder pain and low back pain with pain radiating to the extremities, depression and sleep disruptions. Although the use of equipment is appropriate post-operatively, the medical records indicate neither that this injured worker had any recent surgery nor, is scheduled to have one. As such, there is no indication for use of cold unit at this time. For heat therapy, special equipment is not needed. ODG also state mechanical circulating units with pumps have not been proven to be more effective than passive hot and cold therapy. The requested treatment: purchase of 1 hot /cold therapy unit is not medically necessary and appropriate.

1 interferential unit purchase: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter- Knee & Leg (Acute & Chronic)- Interferential current therapy (IFC).

Decision rationale: Interferential Current Stimulation (ICS) is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and post-operative knee pain. The findings from these trials were either negative or non-interpretible for recommendation due to poor study design and/or methodologic issues. In addition although proposed for treatment in general for soft tissue injury or for enhancing wound or fracture healing, there is insufficient literature to support Interferential current stimulation for treatment of these conditions. There are no standardized protocols for the use of interferential therapy; and the therapy may vary according to the frequency of stimulation, the pulse duration, treatment time, and electrode-placement technique. As per Official Disability Guidelines (ODG) Interferential current therapy (IFC) is under study for osteoarthritis and recovery post knee surgery. Not recommended for chronic pain or low back problems. After knee surgery, home interferential current therapy (IFC) may help reduce pain, pain medication taken, and swelling while increasing range of motion, resulting in quicker return to activities of daily living and athletic activities. Currently, the injured worker complains of continued left shoulder pain and low back pain with pain radiating to the extremities, depression and sleep disruptions. The treating provider's notes do not provide clear indication about this request. Based on the currently available information in the submitted Medical Records of this injured worker, and per review of the guidelines, the medical necessity for Interferential Current Stimulation (ICS) unit has not been established. The requested Treatment for Interferential Current Stimulation (ICS) is not medically necessary.

60 tablets of Vicodin 5/300mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91-97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Opioids.

Decision rationale: According to the CA MTUS and ODG, Vicodin 5/300mg (Hydrocodone/Acetaminophen) is a short-acting opioid analgesic indicated for moderate to moderately severe pain, and is used to manage both acute and chronic pain. The treatment of chronic pain with any

opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there is no documentation of the medication's functional benefit. Medical necessity of the requested item has not been established. Of note, discontinuation of an opioid analgesic should include a taper, to avoid withdrawal symptoms. The requested treatment: 60 tablets of Vicodin 5/300mg are not medically necessary and appropriate.

90 tablets of Fexmid 7.5mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63-65. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter --Muscle relaxants.

Decision rationale: According to the reviewed literature, Cyclobenzaprine (Flexeril) is not recommended for the long-term treatment of chronic pain. This medication has its greatest effect in the first four days of treatment. In addition, this medication is not recommended to be used for longer than 2-3 weeks. According to CA MTUS Guidelines, muscle relaxants are not considered any more effective than non-steroidal anti-inflammatory medications alone. In this case, the available records are not clear if this injured worker has any functional improvement from prior Cyclobenzaprine use. Based on the currently available information and per review of guidelines, the medical necessity for this muscle relaxant medication has not been established. The requested treatment is not medically necessary. According to the reviewed literature, Cyclobenzaprine (Flexeril) is not recommended for the long-term treatment of chronic pain. This medication has its greatest effect in the first four days of treatment. In addition, this medication is not recommended to be used for longer than 2-3 weeks. According to CA MTUS Guidelines, muscle relaxants are not considered any more effective than non-steroidal anti-inflammatory medications alone. In this case, the available records show that the injured worker has not shown a documented benefit or any functional improvement from prior Cyclobenzaprine use. Based on the currently available information, the medical necessity for this muscle relaxant medication has not been established. The requested treatment 90 tablets of Fexmid 7.5mg is not medically necessary.

1 container of Flurbiprofen 20% Lidocaine 5% and Amitriptyline 5% 180gms: Upheld

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

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

Decision rationale: According to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and

anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, muscle relaxants, local anesthetics or antidepressants. Guidelines indicate that any compounded product that contains at least one non-recommended drug (or drug class) is not recommended for use. Flurbiprofen is used as a topical NSAID. It has been shown in a meta-analysis to be superior to placebo during the first two weeks of treatment for osteoarthritis but either, not afterward, or with diminishing effect over another two-week period. There are no clinical studies to support the safety or effectiveness of Flurbiprofen in a topical delivery system (excluding ophthalmic). In this injured worker, the medical necessity for the requested topical cream has not been established. Therefore, as per guidelines stated above, the requested topical cream is not medically necessary.

1 container of Gabapentin 10% Cyclobenzaprine 60% and Tramadol 10% 180gms: Upheld

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

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

Decision rationale: According to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, muscle relaxants, local anesthetics or antidepressants. Guidelines indicate that any compounded product that contains at least one non-recommended drug (or drug class) is not recommended for use. As per MTUS, There is no evidence for use of any other muscle relaxant as a topical product. Gabapentin is not recommended. There is no peer-reviewed literature to support its use. Records do not indicate that injured worker is not able to use oral medications. There is no documentation in the submitted Medical Records that the injured worker has failed a trial of antidepressants and anticonvulsants. In this injured worker, the medical necessity for the requested topical cream has not been established. Therefore, as per guidelines stated above, the requested 1 container of Gabapentin 10% Cyclobenzaprine 60% and Tramadol 10% 180gms cream is not medically necessary.