

Case Number:	CM15-0082396		
Date Assigned:	05/04/2015	Date of Injury:	08/19/2002
Decision Date:	07/01/2015	UR Denial Date:	03/27/2015
Priority:	Standard	Application Received:	04/29/2015

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

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 46 year old male who sustained a work related injury August 19, 2002. Past history included; pain disorder associated with psychological factors and a medical condition; major depressive disorder, single, moderate; and obsessive compulsive disorder. According to a sport neurology and pain management physician's notes, dated March 10, 2015, the injured worker presented for an established follow-up visit for medication review and recheck. Assessment is documented as lesion of ulnar nerve; contracture of hand joint; chronic pain; anxiety and depression. Treatment goals included continue with therapy, refill medication, and at issue, request authorization for Naprosyn, Protonix, TMS (transcranial magnetic stimulation), and transportation to TMS appointments.

IMR ISSUES, DECISIONS AND RATIONALES

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

Transcranial magnetic stimulation: 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), Transcranial Magnetic Stimulation.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress Chapter, Transcranial magnetic stimulation (TMS).

Decision rationale: The patient presents with upper extremity pain, anxiety and depression. The request is for TRANSCRANIAL MAGNETIC STIMULATION. The request for authorization is dated 03/23/15. Physical examination reveals no changes. He continues with allodynia about the UE scars. Mood and affect anxious, apprehensive, tense, depressed, apathetic and flat. Treatment plan goals include increasing the patient's ability to self-manage pain and related problems. Return to productive activity at home, socially, and /or at work. Maximize and maintain optimal physical activity and function. Patient's medications include Naprosyn, Protonix, Tramadol and Norco. Per progress report dated 03/10/15, the patient is permanent and stationary. ODG-TWC, Mental Illness & Stress Chapter, under Transcranial magnetic stimulation (TMS) states: "Recommended for severe treatment-resistant MDD as indicated below. Under study for PTSD, with initial promising results. Transcranial magnetic stimulation (TMS) is a non-invasive method of delivering electrical stimulation to the brain. A magnetic field is delivered through the skull, where it induces electric currents that affect neuronal function. Repetitive TMS (rTMS) is being used as a treatment of depression and other psychiatric/neurologic brain disorders. Criteria for Transcranial magnetic stimulation (TMS): Diagnosis of severe Major Depression when the following criteria are met: Failure of at least 3 different medication trials, from at least 2 different classes, at adequate dose and duration or due to intolerable effects, plus; Failure of a trial of electroconvulsive therapy (ECT) due to inadequate response or intolerable effects or bona-fide contraindication to ECT, OR Failure of at least 4 different antidepressant medication trials, from at least 2 different classes, at adequate dose and duration or due to intolerable effects, OR A positive clinical response to a previous course of treatment with TMS." Per progress report dated 03/10/15, treater's reason for the request is "TMS has been approved by the FDA for the treatment of depression. It also has significant utility in the treatment of chronic and neuropathic pain conditions." Given patient's chronic pain and diagnosis of anxiety and depression, the request for a TMS appears reasonable. However, review of provided reports do not show evidence the patient meets any one of the criteria required by ODG. There is lack of discussion in treatment reports by provider, such as failed medications, failed trial of ECT, or previous treatment with TMS. Therefore, the request IS NOT medically necessary.

Naprosyn (dosage and quantity unspecified): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 47, Chronic Pain Treatment Guidelines Non-steroidal anti-inflammatory drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines anti-inflammatory, medication for chronic pain Page(s): 22, 60-61.

Decision rationale: The patient presents with upper extremity pain, anxiety and depression. The request is for NAPROSYN (DOSAGE AND QUANTITY UNSPECIFIED). The request for authorization is dated 03/23/15. Physical examination reveals no changes. He continues with allodynia about the UE scars. Mood and affect anxious, apprehensive, tense, depressed,

apathetic and flat. Treatment plan goals include increasing the patient's ability to self-manage pain and related problems. Return to productive activity at home, socially, and /or at work. Maximize and maintain optimal physical activity and function. Patient's medications include Naprosyn, Protonix, Tramadol and Norco. Per progress report dated 03/10/15, the patient is permanent and stationary. MTUS Guidelines on anti-inflammatory page 22 states, "Anti-inflammatories are the traditional first line of treatment to reduce pain, so activity and functional restoration can resume, but long term use may not be warranted." Treater does not specifically discuss this medication. The patient has been taking Naproxen since at least 09/29/14; however, review of the reports show no discussions on functional improvement and the effect of pain relief as required by the guidelines. For medication use in chronic pain, MTUS page 60 requires documentation of pain assessment and function as related to the medication use. There is lack of documentation regarding what Naproxen has specifically done for the patient's pain and function and why it is prescribed, as required by MTUS guidelines. Therefore, the request IS NOT medically necessary.

Protonix (dosage and quantity unspecified): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms and cardiovascular risk Page(s): 69.

Decision rationale: The patient presents with upper extremity pain, anxiety and depression. The request is for PROTONIX (DOSAGE AND QUANTITY UNSPECIFIED). The request for authorization is dated 03/23/15. Physical examination reveals no changes. He continues with allodynia about the UE scars. Mood and affect anxious, apprehensive, tense, depressed, apathetic and flat. Treatment plan goals include increasing the patient's ability to self-manage pain and related problems. Return to productive activity at home, socially, and /or at work. Maximize and maintain optimal physical activity and function. Patient's medications include Naprosyn, Protonix, Tramadol and Norco. Per progress report dated 03/10/15, the patient is permanent and stationary. MTUS pg 69 states "NSAIDs, GI symptoms and cardiovascular risk,,: Treatment of dyspepsia secondary to NSAID therapy: Stop the NSAID, switch to a different NSAID, or consider H2-receptor antagonists or a PPI." Regarding Protonix, or a proton pump inhibitor, MTUS allows it for prophylactic use along with oral NSAIDs when appropriate GI risk is present such as age greater 65; concurrent use of anticoagulants, ASA or high dose of NSAIDs; history of PUD, gastritis, etc. This medication also can be used for GI issues such as GERD, PUD or gastritis. Treater does not specifically discuss this medication. Treater does not describe the patient's symptoms nor response to this medication. Although the patient is prescribed Naprosyn, treater does not provide GI risk assessment for prophylactic use of PPI, as required by MTUS. Provided progress report does not show evidence of gastric problems, and there is no mention of GI issues. Furthermore, Protonix is indicated for GERD and erosive esophagitis, which is not discussed, either. Therefore, the request IS NOT medically necessary.

Transportation to TMS (Transcranial magnetic stimulation) appointments: 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 Official Disability Guidelines (ODG) Chapter 'Knee & Leg' and Title 'Transportation (to & from appointments) AETNA on transportation website www.aetna.com.

Decision rationale: The patient presents with upper extremity pain, anxiety and depression. The request is for TRANSPORTATION TO TMS (TRANSCRANIAL MAGNETIC STIMULATION) APPOINTMENTS. The request for authorization is dated 03/23/15. Physical examination reveals no changes. He continues with allodynia about the UE scars. Mood and affect anxious, apprehensive, tense, depressed, apathetic and flat. Treatment plan goals include increasing the patient's ability to self-manage pain and related problems. Return to productive activity at home, socially, and /or at work. Maximize and maintain optimal physical activity and function. Patient's medications include Naprosyn, Protonix, Tramadol and Norco. Per progress report dated 03/10/15, the patient is permanent and stationary. ODG-TWC guidelines, Chapter 'Knee & Leg' and Title 'Transportation (to & from appointments)', recommend transportation "for medically-necessary transportation to appointments in the same community for patients with disabilities preventing them from self-transport. (CMS, 2009) Note: This reference applies to patients with disabilities preventing them from self-transport who are age 55 or older and need a nursing home level of care. Transportation in other cases should be agreed upon by the payer, provider and patient, as there is limited scientific evidence to direct practice." AETNA has the following guidelines on transportation: Per AETNA guidelines, "The cost of transportation primarily for, and essential to, medical care is an eligible medical expense. The request must be submitted for reimbursement and the request should document that patient cannot travel alone and requires assistance of a nurse or companion." Treater does not discuss this request. In this case, while the patient suffers from pain, there is no indication that he requires nursing home level care. Furthermore, if the patient was to undergo TMS, it is a non-invasive treatment that does not require sedation. However, the requested TMS has not been deemed medically necessary. Therefore, this request IS NOT medically necessary.