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| Case Number: | CM14-0114354 | | |
| Date Assigned: | 08/04/2014 | Date of Injury: | 12/20/2013 |
| Decision Date: | 09/30/2014 | UR Denial Date: | 06/24/2014 |
| Priority: | Standard | Application Received: | 07/22/2014 |

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. The expert reviewer is Board Certified in Family Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 is a 55-year-old male who reported an industrial injury on 12/20/2013, nine (9) months ago, attributed to the performance of his customary work tasks reported as cumulative trauma affecting the spine, upper and lower extremities, hips, heels, internal an aggravation of cardiac condition and sleep disorder. The patient has been treated with medications, physical therapy, acupuncture, and activity modifications. MRI of the left shoulder documented rotator cuff tendinosis with small partial thickness bursal side tear distal supraspinatus tendon, and inferior lateral tilting of the acromion with degenerative changes of AC joint with increased risk for impingement. The electromyography/nerve conduction velocity (EMG/NCV) of the bilateral lower extremities dated 2/2/2014 documented evidence of chronic bilateral S1 radiculopathy; no evidence of acute lumbar radiculopathy; no evidence of entrapment neuropathy was noted at any level and bilateral lower extremities. The EMG/NCV of the bilateral upper extremities documented no electro neural graphic indicators of carpal tunnel syndrome or ulnar neuropathy were noted in the bilateral upper extremities; electromyographic indicators of acute cervical radiculopathy were not noted. The patient continued to complain of significant back pain, left hip pain, and left shoulder pain. The objective findings on examination included left shoulder decreased range of motion; positive impingement test; tenderness to palpation anterior shoulder; lumbar spine with tenderness to palpation and spasms; restricted range of motion to the lumbar spine; SLR positive on the left; reduce sensation to the left foot; tenderness to palpation on the medial collateral ligaments bilaterally to the knees; normal range of motion to the knees; negative McMurray's; tenderness to palpation on the greater trochanteric; range of motion slightly reduced with abduction and abduction. The diagnoses included internal derangement of the knee; lumbar radiculopathy; enthesopathy of hip; unspecified derangement of the shoulder; bicipital tenosynovitis; the patient was continued on total temporary disability TTD status. The

treatment plan included aquatic therapy 3 times per week time 4 weeks; Capsaicin topical cream; Soma 350 mg; referral to a cardiologist; MRI of the left shoulder to rule out rotator cuff tear; MRI of the thoracic spine to rule out herniated disk; acupuncture treatment 3 x4 to the low back hip, shoulder; follow-up with orthopedist in regard to hip pathologies.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy for left knee, left hip, left shoulder and back #12: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines Page(s): 99.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299-300, Chronic Pain Treatment Guidelines PHYSICAL MEDICINE Page(s): 97-98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) neck and upper back chapter-PT; back chapter-PT; Hip chapter--PT; shoulder chapter--PT; knee and leg chapter--PT.

Decision rationale: The request is for authorization of 12 additional sessions of PT to the back, hip, shoulder, and knee nine (9) months after the date of injury (DOI) exceeds the number of sessions of PT recommended by the CA MTUS and the time period recommended for rehabilitation. The evaluation of the patient documented no objective findings on examination to support the medical necessity of physical therapy nine (9) months after the cited DOI with no documented weakness or muscle atrophy as opposed to a self-directed home exercise program (HEP). There are no objective findings to support the medical necessity of 12 additional sessions of physical therapy for the rehabilitation of the patient over the number recommended by evidence-based guidelines. The patient is documented with no signs of weakness, no significant reduction of range of motion (ROM), or muscle atrophy. There is no demonstrated medical necessity for the prescribed PT to the back, hip, knee, shoulder nine (9) months after the DOI. The patient is not documented to be in HEP. There is no objective evidence provided by the provider to support the medical necessity of the requested eight additional sessions of PT over a self-directed home exercise program. The CA MTUS recommend up to nine (9) sessions of physical therapy over 8 weeks for the hip for sprain/strains or DJD. The CA MTUS recommends up to ten (10) sessions of physical therapy over eight (8) weeks for the rehabilitation of the shoulder subsequent to the diagnosis of sprain/strain or impingement. The CA MTUS recommends a total of nine (9) sessions over 8 weeks for the rehabilitation of the knee or left extremity (LE) s/p sprain/strain with integration into a self-directed home exercise program. The CA MTUS recommends ten (10) sessions of physical therapy over 8 weeks for the lumbar spine rehabilitation subsequent to lumbar strain/sprain and lumbar spine Degenerative Disc Disease DDD with integration into HEP. The provider did not provide any current objective findings to support the medical necessity of additional PT beyond the number recommended by evidence-based guidelines. There is no demonstrated medical necessity for the requested additional 12 sessions of PT.

MRI of the bilateral hip: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Hip & Pelvis - MRI (magnetic resonance imaging).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip and Pelvis chapter---MRI.

Decision rationale: There were no documented interval changes in the objective findings on examination to the bilateral hips to support the medical necessity of MRI studies. The requesting physician failed to document any interval changes in the clinical status of the patient to support the medical necessity of the requested MRIs of the hips. The request for MRIs of the bilateral hips represent screening studies ordered to rule out pathology. There are no documented objective findings on examination to support the medical necessity of the requested imaging studies. There were no x-ray findings the bilateral hips documented to support the medical necessity of the MRI studies. There are no diagnoses documented by the requesting physician for the hips. There is documented change in the clinical status of the hips since the date of injury. The request for MRIs of the right/left hip is made without any other provided conservative care. The repeated MRIs of the bilateral hips showed screening exams that had no rationale or objective evidence to support medical necessity. The objective findings recommended by the ACOEM Guidelines 2nd edition and the Official Disability Guidelines for the authorization of an MRI of the Hip were not documented in the available clinical documentation. The request for authorization of bilateral hip MRIs is not demonstrated to be medically necessary.

Capsaicin 0.1% Cream: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47, Chronic Pain Treatment Guidelines anti-inflammatory medications pages 22, 67-68, muscle relaxants page 63; topical analgesics pages 111-113; topical Capsaicin--page 28-29 Page(s): 22, 67-68; 63; 111-113; 28-29. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter cyclobenzaprine; muscle relaxants; topical analgesics; topical analgesics compounded.

Decision rationale: The prescription for the topical analgesic Capsaicin 0.1% cream is not medically necessary for the treatment of the patient for pain relief for the orthopedic diagnoses of the patient. There is clinical documentation submitted to demonstrate the use of the topical gels for appropriate diagnoses or for the recommended limited periods of time. It is not clear that the topical compounded medications are medically necessary in addition to prescribed oral medications. There is no provided subjective/objective evidence that the patient has failed or not responded to other conventional and recommended forms of treatment for relief of the effects of the industrial injury. Only if the subjective/objective findings are consistent with the recommendations of the ODG, then topical use of topical preparations is only recommended for

short-term use for specific orthopedic diagnoses. There is no provided rationale supported with objective evidence to support the prescription of the topical compounded cream. There is no documented efficacy of the prescribed topical compounded analgesics with no assessment of functional improvement. The patient is stated to have reduced pain with the topical creams however there is no functional assessment and no quantitative decrease in pain documented. The use of topical compounded analgesics is documented to have efficacy for only 2-4 weeks subsequent to injury and thereafter is not demonstrated to be as effective as oral NSAIDs. There is less ability to control serum levels and dosing with the topical. The patient is not demonstrated to have any GI issue at all with NSAIDs or the prescribed analgesics. There is no demonstrated medical necessity for topical NSAIDs for chronic pain for a prolonged period of time. The request for the topical Capsaicin 0.1% cream is not medically necessary for the treatment of the patient for the diagnosis of the chronic pain to multiple body sites. The use of the topical gels does not provide the appropriate therapeutic serum levels of medications due to the inaccurate dosing performed by rubbing variable amounts of gels on areas that are not precise. The volume applied and the times per day that the gels are applied are variable and do not provide consistent serum levels consistent with effective treatment. There is no medical necessity for the addition of gels to the oral medications in the same drug classes. There is no demonstrated evidence that the topical are more effective than generic oral medications. The use of Capsaicin 0.1% cream not supported by the applicable evidence-based guidelines as cited above. The continued use of topical NSAIDs for the current clinical conditions is not otherwise warranted or demonstrated to be appropriate. There is no documented objective evidence that the patient requires both the oral medications and the topical analgesic medication for the treatment of the industrial injury. The prescription for Capsaicin 0.1% cream is not medically necessary for the treatment of the patient's chronic pain complaints. The prescription of Capsaicin 0.1% cream is not recommended by the CA MTUS, ACOEM guidelines, and the Official Disability Guidelines. The continued use of topical NSAIDs for the current clinical conditions is not otherwise warranted or appropriate--noting the specific comment, "There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip, or shoulder." The objective findings in the clinical documentation provided do not support the continued prescription of for the treatment of chronic pain.

Carisoprodol 350mg #60 x 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 65.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47, Chronic Pain Treatment Guidelines Official Disability Guidelines (ODG) Pain Chapter--muscle relaxants and Carisoprodol Page(s): 66. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter--muscle relaxants and Carisoprodol.

Decision rationale: The patient is prescribed Carisoprodol/Soma 350 mg #60 with refill x2 on a routine basis for the treatment of chronic pain and is not directed to muscle spasms on a prn basis. The CA MTUS does not recommend the prescription of Carisoprodol. There is no medical necessity for the prescribed Soma 350 mg #60 for chronic pain or muscle spasms, as it is not recommended by evidence-based guidelines. The prescription of Carisoprodol is not recommended by the CA MTUS for the treatment of injured workers. The prescription of

Carisoprodol as a muscle relaxant is not demonstrated to be medically necessary for the treatment of the chronic back pain on a routine basis. The patient has been prescribed Carisoprodol on a routine basis for muscle spasms. There is no demonstrated medical necessity for the daily prescription of Carisoprodol as a muscle relaxer on a daily basis for chronic pain. The prescription of Carisoprodol for use of a muscle relaxant for cited chronic pain is inconsistent with the recommendations of the CA MTUS, the ACOEM Guidelines, and the Official Disability Guidelines. The use of alternative muscle relaxants was recommended by the CA MTUS and the Official Disability Guidelines for the short-term treatment of chronic pain with muscle spasms; however, muscle relaxants when used are for short-term use for acute pain and are not demonstrated to be effective in the treatment of chronic pain. The use of Carisoprodol is associated with abuse and significant side effects related to the psychotropic properties of the medication. The centrally acting effects are not limited to muscle relaxation. The prescription of Carisoprodol as a muscle relaxant is not recommended as others muscle relaxants that without psychotropic effects are readily available. There is no medical necessity for Carisoprodol 350 mg #60. There are clearly no recommendations for the prescribed combination of Valium and Carisoprodol due to the psychotropic effects. The California MTUS guidelines state that Carisoprodol is not recommended. This medication is not indicated for long-term use. Carisoprodol is a commonly prescribed centrally acting skeletal muscle relaxant whose primary active metabolite is Meprobamate a schedule for controlled substance. It has been suggested that the main effect is due to generalize sedation and treatment of anxiety. Abuses been noted for sedative and relaxant effects. In regular abusers, the main concern is for the accumulation of Meprobamate. Carisoprodol abuses also been noted in order to augment or alter effects of other drugs. This includes the following increasing sedation of benzodiazepines or alcohol; used to prevent side effects of cocaine; use with tramadol to ghost relaxation and euphoria; as a combination with Hydrocodone as an effective some abuses claim is similar to Heroin referred to as a Las Vegas cocktail; and as a combination with Codeine referred to as Carisoprodol coma. There is no documented functional improvement with the use of the prescribed Carisoprodol. The use of Carisoprodol/Soma is not recommended due to the well-known psychotropic properties. Therefore, this medication should be discontinued. There is no demonstrated medical necessity for Soma 350 mg #60 with refill x2.

Cardiologist evaluation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 127.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 92. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) chapter 7 page 127; Official Disability Guidelines (ODG) Knee chapter---knee arthroplasty.

Decision rationale: There was no rationale provided to support the medical necessity of the Cardiology consultation in relation to the industrial injury other than the patient other than the patient was reported to have left ventricular hypertrophy. There was no rationale supported by objective evidence to support the medical necessity of a cardiac evaluation. There was no demonstrated or evaluated etiology of the reported left ventricular hypertrophy in relation to cardiac disease. There was no cardiac history or any history of heart problems. The treating

physician provided no evidence of a heart or cardiac industrial issue for which a Cardiology consultation would be medically necessary, as there were no objective findings on examination or an EKG. There was no provided nexus to the industrial injury. There was no provided evidence to support an aggravation or exacerbation of the underlying medical issues of the patient that are described as comorbid medical issues. There is no objective evidence provided by physician to support the medical necessity of a Cardiology consultation on an industrial basis. The treating physician fails to provide a rationale for the medical necessity of a Cardiac consultation for the industrial treatment of an underlying medical issue. There were no demonstrated cardiac issues on the provided PR-2 reports and the objective findings on examination did not include any assessment of the heart.