

Case Number:	CM14-0146489		
Date Assigned:	09/12/2014	Date of Injury:	12/01/2009
Decision Date:	10/24/2014	UR Denial Date:	08/19/2014
Priority:	Standard	Application Received:	09/09/2014

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 Internal Medicine and is licensed to practice in North Carolina, Colorado, California, and Kentucky. 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:

The injured worker is a 47 year old female injured on 12/01/09 as a result of continuous trauma to the bilateral upper extremities resulting in gradual onset of pain, numbness, tingling, and swelling of the bilateral hands, right greater than left, and neck pain. The injured worker was initially treated with medications and physical therapy in addition to activity modifications. The injured worker underwent multiple sessions of acupuncture for the neck, shoulder, and elbow. The clinical note dated 05/01/14 indicated the injured worker presented complaining of persistent neck pain rated at 7/10, right shoulder pain rated at 7/10, and right elbow pain rated at 5/10. The injured worker reported radiation of pain into the lower extremities with weakness and numbness. Physical examination revealed limited range of motion in the cervical spine, palpable tenderness over the trapezius/paravertebrals equally, hypertonicity over the trapezius equally, positive shoulder depression, Spurling's on the right, cervical compression, muscle strength 4/5 at C5 through C8 bilaterally, sensation 4/5 at bilateral C7 and C8. Diagnoses include cervical spine disc herniation. The injured worker reported TENS unit provided some relief; however, requested something stronger. Request for an H-wave unit submitted. Additional requests for acupuncture therapy to the cervical spine 2 x a week for 4 weeks requested. The initial request was non-certified on 08/18/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI Right Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208-9. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder (Acute & Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Shoulder complaints, Special studies and Diagnostics and Treatment Considerations

Decision rationale: As noted in the ACOEM Guidelines, the primary criteria for ordering imaging studies are emergence of a red flag (e.g., indications of intra-abdominal or cardiac problems presenting as shoulder problems), physiologic evidence of tissue insult or neurovascular dysfunction (e.g., cervical root problems presenting as shoulder pain, weakness from a massive rotator cuff tear, or the presence of edema, cyanosis or Raynaud's phenomenon), failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to an invasive procedure (e.g., a full thickness rotator cuff tear not responding to conservative treatment). The clinical documentation fails to provide the necessary information to substantiate the above mentioned criteria. As such, the request cannot be recommended as medically necessary.

Acupuncture x 12 for the Right Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines: Shoulder Acute and Chronic

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: As noted in the MTUS Acupuncture Guidelines, the frequency and duration of acupuncture or acupuncture with electrical stimulation may be performed 1 to 3 times per week with an optimum duration over 1 to 2 months. Guidelines indicate that the expected time to produce functional improvement is 3 to 6 treatments. Acupuncture treatments may be extended if functional improvement is documented. Current guidelines recommend an initial trial period of 3 - 4 sessions over 2 weeks with evidence of objective functional improvement prior to approval of additional visits. Documentation indicates the injured worker has undergone multiple sessions of acupuncture; however, continues to complain of significant pain. Additionally, evidence of functional improvement as a result of acupuncture was not provided. As such, the request for Acupuncture x 12 for the Right Shoulder cannot be recommended as medically necessary.

Flurbiprofen/ Tramadol /Ranitidine 100/100/100mg #90: Upheld

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

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

Decision rationale: The MTUS Chronic Pain Guidelines state that the safety and efficacy of compounded medications has not been established through rigorous clinical trials. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Further, the MTUS Chronic Pain Guidelines, Food and Drug Administration, and Official Disability Guidelines require that all components of a compounded topical medication be approved for transdermal use. This compound contains Flurbiprofen, Tramadol, and Ranitidine which have not been approved for transdermal use. There is no indication these types of medications have been trialed and or failed. In addition, there is no evidence within the medical records submitted that substantiates the necessity of a transdermal versus oral route of administration. As such, the request is not medically necessary and appropriate.

Diclofenac/ Lidocaine 3%/5% 180g #1: 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 Topical Analgesics, Page(s): , page(s) 111.

Decision rationale: As noted on page 111 of the MTUS Chronic Pain Guidelines, the safety and efficacy of compounded medications has not been established through rigorous clinical trials. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no indication these types of medications have been trialed and or failed. In addition, there is no evidence within the medical records submitted that substantiates the necessity of a transdermal versus oral route of administration. As such, the request is not medically necessary and appropriate.

Ultram 50mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Long-Term Users of Opioids (6 Months or More) Opioids, Cri.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use of Opioids, Page(s): 77.

Decision rationale: As noted on page 77 of the MTUS Chronic Pain Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. Specific examples of improved functionality should be provided to include individual activities of daily living, community activities, and exercise able to perform as a result of medication use. As such, Ultram 50mg #120 cannot be recommended as medically necessary at this time.