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| Case Number: | CM14-0168023 | | |
| Date Assigned: | 10/15/2014 | Date of Injury: | 12/26/2013 |
| Decision Date: | 11/18/2014 | UR Denial Date: | 09/22/2014 |
| Priority: | Standard | Application Received: | 10/13/2014 |

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Management 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:

The patient is a 40 year old male with an injury date on 12/26/2013. Based on the 09/15/2014 progress report provided by [REDACTED], the diagnoses are:1. Head pain2. Cervical musculoligamentous strain/sprain with radiculitis3. Rule out cervical spine discogenic disease4. Thoracic musculoligamentous strain/sprain with radiculitis5. Lumbar musculoligamentous strain/sprain with radiculitis6. Rule out lumbar spine discogenic disease7. Chest/abdominal pain8. Bilateral wrist strain/strain9. Bilateral wrist carpal tunnel syndrome10. Rule out bilateral wrist chronic overuse syndrome11. Rule out internal problems/injury12. Severe obesity13. Depression, situational14. Sleep disturbance secondary to pain According to this report, the patient complains of headache at 4/10, neck pain at 8/10, mid/upper back at 6-7/10 and lower back pain at 6-7/10. The patient also complains of numbness at the bilateral wrist; pain is at a 5/10. Physical exam reveals 3-4 tenderness to palpation over the cervical/ thoracic/lumbar paraspinal muscles. Range of motion of all three regions is restricted. There is grade 2 tenderness to palpation at the bilateral wrist and hand. The 08/18/2014 report reveals positive compression test and straight leg raise test. There were no other significant findings noted on this report. The utilization review denied the request on 09/22/2014. [REDACTED] is the requesting provider, and he provided treatment reports from 03/25/2014 to 09/15/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flurbiprofen 20%/Tramadol 20% 210gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

Decision rationale: According to the 09/15/2015 report by [REDACTED] this patient presents with headache at 4/10, neck pain at 8/10, mid/upper back at 6-7/10 and lower back pain at 6-7/10. The provider is requesting Flurbiprofen 20%/Tramadol 20% 210gm. Regarding topical NSAIDS, MTUS guidelines recommends for "Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment." In this case, the patient does not meet the indication for a topical NSAID as the patient does not present with peripheral joint arthritis/tendinitis problems. MTUS states that if one of the compounded topical component is not recommended, then the entire compound is not recommended. Furthermore, Tramadol is not discussed in any of the guidelines for topical formulation. Recommendation is for denial.

Amitriptyline 10%/Dextromethorphan 10%/Gabapentin 10% 210gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines chronic pain section Page(s): 111-113.

Decision rationale: According to the 09/15/2015 report by [REDACTED] this patient presents with headache at 4/10, neck pain at 8/10, mid/upper back at 6-7/10 and lower back pain at 6-7/10. The provider is requesting Amitriptyline 10%/Dextromethorphan 10%/Gabapentin 10% 210gm. Regarding topical compounds, MTUS states that if one of the compounded product is not recommended then the entire compound is not recommended. In this case, Gabapentin is not recommended for topical formulation. Recommendation is for denial.

12 physical therapy visits for the bilateral wrists, cervical, thoracic, and lumbar spine:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: According to the 09/15/2015 report by [REDACTED] this patient presents with headache at 4/10, neck pain at 8/10, mid/upper back at 6-7/10 and lower back pain at 6-7/10. The provider is requesting 12 physical therapy visits for the bilateral wrists, cervical, thoracic, and lumbar spine. For physical medicine, the MTUS guidelines recommend for myalgia and myositis type symptoms 9-10 visits over 8 weeks. Review of physical therapy report dated 09/12/2014 shows that the patient has had 7 sessions with pain and spasm "same."

Given that the patient has had 7 sessions recently, the requested 12 additional sessions exceed what is allowed per MTUS. Recommendation is for denial.

Extracorporeal shockwave therapy (4) - for the cervical spine: 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)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), low back chapter under shockwave therapy

Decision rationale: According to the 09/15/2015 report by [REDACTED] this patient presents with headache at 4/10, neck pain at 8/10, mid/upper back at 6-7/10 and lower back pain at 6-7/10. The provider is requesting 4 sessions of extracorporeal shockwave therapy for the cervical spine. Regarding ESWT, MTUS and ODG does not discuss ESWT for the cervical spine, however ODG guidelines does discuss ESWT for the spine. ODG states "Not recommended. The available evidence does not support the effectiveness of ultrasound or shock wave for treating LBP. In the absence of such evidence, the clinical use of these forms of treatment is not justified and should be discouraged." Recommendation is for denial.