

Case Number:	CM14-0090373		
Date Assigned:	08/08/2014	Date of Injury:	02/25/2013
Decision Date:	09/15/2014	UR Denial Date:	06/09/2014
Priority:	Standard	Application Received:	06/17/2014

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 Orthopedic Surgery, has a subspecialty in Orthopedic Sports Medicine and is licensed to practice in Texas. 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 29 year old male who sustained injury on 02/25/13 due to constant and repetitive motion. The injured worker developed multiple complaints including pain in the neck right shoulder and low back. Prior MRI of the right shoulder was unremarkable. The injured worker was followed for concurrent psychological complaints due to chronic pain. Other treatment included physical therapy application of heat and cold therapy ultrasound electrical stimulation multiple medications acupuncture and chiropractic treatment without benefit. MRI of the lumbar spine in 06/13 noted annular tearing at L4-5 and 2mm disc bulge resulting in neural foraminal stenosis moderate to severe secondary to facet joint hypertrophy. MRI of the cervical spine from the same time period noted small 1-2mm disc bulges from L C3 from C4 to C7 without evidence of stenosis. The most recent report was from 04/23/14 which was handwritten and very difficult to interpret due to handwriting and copy quality. Per the record the injured worker had continuing complaints of right shoulder pain. No specific physical examination findings could be discerned. There appeared to be recommendation for MRI arthrogram of the right shoulder. The requested services including caudal epidural decompression neuroplasty at L4-5 with local anesthesia steroids and other medications facet joint injections with fluoroscopic guidance myoneural injections right super scapular nerve block injection with shoulder manipulation right shoulder cortisone injections topical compounded medications including Ketoprofen Lidocaine and Gabapentin cold therapy unit and interferential unit for home use were denied by utilization review on 06/09/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Caudal epidural decompression neuroplasty at L4-5 with local anesthesia, steroids and associated med: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter.

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, Caudal Neuroplasty.

Decision rationale: In regards to the request for caudal epidural decompression neuroplasty at L4-5 with local anesthesia steroids and associated medications, this reviewer would not have recommended this request as medically necessary. The most recent clinical record from April of 2014 did not discuss this procedure and focused on the right shoulder. Per guidelines decompression neuroplasty is not recommended due to the lack of evidence regarding its efficacy versus risk factors for the procedure. Given the lack of any clear clinical indications for this procedure this reviewer would not have recommended this request as medically necessary.

Myoneural injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 2009 Page(s): 122.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Botulinum toxin Page(s): 25-26.

Decision rationale: In regards to the request for myoneural injections, this reviewer would not have recommended this request as medically necessary. There was no specific discussion of this procedure in the last clinical records provided for review. The right shoulder condition was discussed. There was no objective evidence supporting the procedure as outlined by guideline recommendations. Therefore this reviewer would not have recommended this request as medically necessary.

Right suprascapular nerve block injection with shoulder manipulation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205, 212-214.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Suprascapular Block and manipulation under anesthesia.

Decision rationale: In regards to the request for right suprascapular nerve block injection with manipulation, this reviewer would not have recommended this request as medically necessary.

There was no specific discussion of this procedure in the last clinical records provided for review. The right shoulder condition was discussed. There was no objective evidence supporting the procedure as outlined by guideline recommendations. Therefore this reviewer would not have recommended this request as medically necessary.

Right shoulder cortisone injection: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Injections.

Decision rationale: In regards to the request for right shoulder cortisone injection, this reviewer would not have recommended this request as medically necessary. There was no specific discussion of this procedure in the last clinical records provided for review. The right shoulder condition was discussed. There was no objective evidence supporting the procedure as outlined by guideline recommendations. Therefore this reviewer would not have recommended this request as medically necessary.

Topical compound cream with keto/lido, gabapentin: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 2009 Page(s): 111-113.

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

Decision rationale: In regards to the use of a compounded topical medication to include Ketoprofen, Lidocaine, and Gabapentin, this reviewer would not have recommended this medication as medically necessary based on the clinical documentation provided for review and current evidence based guideline recommendations. The CA MTUS Chronic Pain Treatment Guidelines and US FDA note that the efficacy of compounded medications has not been established through rigorous clinical trials. The FDA requires that all components of compounded topical medication be approved for transdermal use. This compound contains Ketoprofen and Gabapentin which are not approved for transdermal use. The clinical documentation provided did not discuss the claimant's prior medication use and did not indicate that there were any substantial side effects with the oral version of the requested medication components. Therefore, this compound cannot be supported as medically necessary.

Cold Therapy unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Knee Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Continuous Cryotherapy.

Decision rationale: In regards to the use of a cold therapy unit, this reviewer would not have recommended this medication as medically necessary based on the clinical documentation provided for review and current evidence based guideline recommendations. The use of a cold therapy unit is supported in the peri-operative period following certain procedures for the knee and leg. There is no post-operative conditions for this injured worker that would support the use of this unit. As such, the request is not medically necessary.

Interferential unit for home use: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrical Stimulation Page(s): 113-117.

Decision rationale: In regards to the request for an interferential unit for home use, this reviewer would not have recommended this request as medically necessary. There was no specific discussion of this procedure in the last clinical records provided for review. The right shoulder condition was discussed. There was no objective evidence supporting the procedure as outlined by guideline recommendations. Therefore this reviewer would not have recommended this request as medically necessary.

Facet injections with fluoroscopic guidance: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

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, Facet Injections, Diagnostic.

Decision rationale: In regards to the request for facet joint injections with fluoroscopic guidance, this reviewer would not have recommended this request as medically necessary. There was no specific discussion of this procedure in the last clinical records provided for review. The right shoulder condition was discussed. There was no objective evidence supporting the procedure as outlined by guideline recommendations. Therefore this reviewer would not have recommended this request as medically necessary.