

Case Number:	CM14-0095321		
Date Assigned:	09/15/2014	Date of Injury:	08/14/2012
Decision Date:	10/15/2014	UR Denial Date:	05/30/2014
Priority:	Standard	Application Received:	06/23/2014

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 43 year old patient had a date of injury on 8/14/2012. The mechanism of injury was not noted. In a progress noted dated 5/15/2014, subjective findings included continued symptoms of pain, numbness, and tingling in right hand and wrist. She continues in postoperative physical therapy for her right shoulder and has 4 visits remaining. On a physical exam dated 5/15/2014, objective findings included she is obese, and there is tenderness in the lower lumbar paravertebral musculature. There is decreased sensation to pinprick over the right hand/wrist. The diagnostic impression shows status post right shoulder arthroscopy, right carpal tunnel syndrome, status post left carpal tunnel release, low back pain. Treatment to date: medication therapy, behavioral modification, right shoulder arthroscopy on 2/20/2014, left carpal tunnel release 4/22/2013A UR decision dated 5/30/2014 denied the request for Surgi/stim unit rental for 6 weeks, stating neuromuscular electrical stimulation is not recommended, and there is documentation that postoperative conditions limited the ability to perform physical therapy. Transportation to and from the hospital/surgical center was denied, stating the patient is married with no documentation that a support system is lacking in which the patient would require assistance. Norco 10/325mg bid #60x2 and Zanaflex 2mg bid #60 x2 was denied, stating no documentation of quantifiable pain relief and functional improvement, and there was lack of documentation of aberrant behaviors. Ultracin lotion BID #120 x2 was denied stating there was little evidence of topical NSAIDs for treatment of osteoarthritis of spine, hip and shoulder. Postoperative physical therapy 3x a week for 4 weeks, #12 was denied, stating that 6 sessions is appropriate, and additional session would be requested with documentation of functional benefit. Cryotherapy unit rental x 6 weeks was denied, stating that a 7 day rental post-surgically is supported.

IMR ISSUES, DECISIONS AND RATIONALES

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

SurgiStim unit rental for six weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy; Transcutaneous electrical nerve sti.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-118.

Decision rationale: CA MTUS state that the Surgi/Stim unit incorporates interferential, NMS/EMS, and galvanic therapies into one unit. However, there is no documentation of a rationale identifying why a combined electrotherapy unit would be required as opposed to a TENS unit. In addition, MTUS does not consistently recommend interferential, NMS, and galvanic electrotherapy. In the 5/15/2014 progress report, and in the reports viewed, there was clear no rationale provided regarding why a combined electrotherapy unit would required postoperatively. Therefore, the request for Surgi/stim unit rental for 6 weeks is not medically necessary.

Transportation to and from the Hospital/surgical center: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Department of Health Care Services-California, Criteria for Medical Transportation, R-15-98E, Criteria Manual Chapter 12.1.

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

Decision rationale: MTUS does not address this issue. ODG states that transportation to and from medical appointments is recommended for medically-necessary transportation to appointments in the same community for patients with disabilities preventing them from self-transport. In the 5/15/2014 progress report, and in the reports viewed, there was no clear rationale provided regarding the medical necessity of transportation to hospital. Therefore, the request for transportation to and from hospital/surgical center is not medically necessary.

Norco 10/325mg, #60, with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78-81.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines do not support ongoing opioid treatment unless prescriptions are from a single practitioner and are taken as

directed; are prescribed at the lowest possible dose; and unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. In the 5/15/2014, there was no documented objective functional improvement noted from the opioid regimen. The patient continues to complain of low back pain, neck pain, and stiffness, and there was no discussion regarding why this patient needs an additional 2 refills. Therefore, the request for Norco 10/325mg, #60 x2 is not medically necessary.

Zanaflex 2mg, #60, with 2 refills: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain); Antispasticity/Antispasmodic drugs..

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 41-42.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines state that Tizanidine is a centrally acting alpha2-adrenergic agonist that is FDA approved for management of spasticity and off label use for low back pain. In addition, MTUS also states that muscle relaxants may be effective in reducing pain and muscle tension, and increasing mobility. However, in most LBP (low back pain) cases, they show no benefit beyond NSAIDs in pain and overall improvement. Also there is no additional benefit shown in combination with NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. In the 5/15/2014 progress report, there was no documentation of an acute exacerbation of pain or muscle spasms noted. Furthermore, this patient has been documented to be on Zanaflex since at least 1/2014, and guidelines do not support long term use. Therefore, the request for Zanaflex 2mg, #60 x2 is not medically necessary.

Ultracin lotion AP, BID, 120 grams, with 2 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 25, 38, 111-113. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: FDA:Ultracin

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines state that ketoprofen, lidocaine (in creams, lotion or gels), capsaicin in anything greater than a 0.025% formulation, baclofen, Boswellia Serrata Resin, and other muscle relaxants, and gabapentin and other antiepilepsy drugs are not recommended for topical applications. In addition, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The FDA states that Ultracin is a combination of methyl salicylate, menthol, and capsaicin. In the 5/15/2014 progress report, there was no documentation of a failure of 1st line oral analgesic to justify the use of this medication. Furthermore, there was no rationale provided regarding why this patient could not use over the counter formulations such as Ben-Gay. Therefore, the request for Ultracin lotion Apply BID #120 x2 is not medically necessary.

Postoperative Physical Therapy 3 times a week for four weeks; twelve visits: 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 Page(s): 98- and 114. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) shoulder chapter

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines support an initial course of physical therapy with objective functional deficits and functional goals. CA MTUS stresses the importance of a time-limited treatment plan with clearly defined functional goals, frequent assessment and modification of the treatment plan based upon the patient's progress in meeting those goals, and monitoring from the treating physician regarding progress and continued benefit of treatment is paramount. Physical Medicine Guidelines - Allow for fading of treatment frequency. ODG recommends 24 visit over 14 weeks postsurgically for shoulder arthroscopy. In a 4/1/2014 progress report, the patient had completed 12 postsurgical physical therapy sessions, and the treatment plan was to continue treatment with 12 additional sessions. However, in the reports viewed, there was no discussion regarding the objective functional improvements from these previous sessions to justify an additional 12 sessions. Therefore, the request for post op physical therapy visit 3x/week x4 is not medically necessary.

Cryotherapy unit rental for six weeks: 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) Carpal Tunnel Syndrome Chapter, continuous cold therapy (CCT) section.

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

Decision rationale: MTUS does not address this issue. ODG states that continuous-flow cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In the 5/15/2014 progress report, and in the reports viewed, there was no clear rationale provided regarding the medical necessity of cryotherapy beyond the 7 day recommended maximum. Therefore, the request for cryotherapy unit rental x 6 weeks is not medically necessary.