MAXIMUS Federal Services

Case Number:	CM15-0111082		
Date Assigned:	06/22/2015	Date of Injury:	05/07/2013
Decision Date:	10/06/2015	UR Denial Date:	05/11/2015
Priority:	Standard	Application Received:	06/09/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: California
Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 42-year-old male with an industrial injury dated 05/07/2013. His diagnosis included cervical spine sprain/strain, lumbar spine sprain/strain and bilateral shoulder impingement syndrome. Prior treatment included physical therapy, medications, psychological evaluation, and shockwave treatment. He presents on 04/09/2015 with complaints of neck, right and left hand pain. This information is taken from a more detailed note dated 02/24/2015. On this date, he was complaining of neck pain with radiation to his left shoulder. He rates the pain as 7/10. He states on a good day his pain is 7 and on a bad day his pain increases to 8. He has frequent headaches with stiffness in the neck. Medications and rest temporary relieve the pain. He also complains of left shoulder pain and low back pain. He also complains of a severe, chronic depressed mood since his injury. Documentation in the 04/09/2015 notes decreased range of motion of the cervical and lumbar spine. Right hand was tender and there was pain in left hand. The treatment plan included medications, ortho consult, and shockwave for bilateral wrists, physical therapy, pain management and urine test for toxicology. The request is for acupuncture 1 times 4 weeks, Anaprox 550 mg # 30, Compound: Ketoprofen and Flurbiprofen 120 gm, Flexeril 7.5 mg, general ortho consult for left shoulder and right hand, ortho shockwave bilateral wrists, pain management for cervical and lumbar spine, physical therapy 2 times 4 weeks, Prilosec 20 mg, Tramadol ER 150 mg and urinalysis test for toxicology.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ortho-Shockwave Bilateral Wrists: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, and Wrist, & Hand (Acute & Chronic) Extracorporeal shock wave therapy (ESWT).

Decision rationale: Limited evidence exists regarding extracorporeal shock wave therapy (ESWT) in reducing pain and improving function. While it appears to be safe, there is disagreement as to its efficacy. Insufficient high quality scientific evidence exists to determine clearly the effectiveness of this therapy. Ortho-Shockwave Bilateral Wrists is not medically necessary.

Urinalysis test for toxicology: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Urine drug screen. Decision based on Non-MTUS Citation ODG-TWC Pain Procedure Summary Urine Drug Testing.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 43.

Decision rationale: Limited evidence exists regarding extracorporeal shock wave therapy (ESWT) in reducing pain and improving function. While it appears to be safe, there is disagreement as to its efficacy. Insufficient high quality scientific evidence exists to determine clearly the effectiveness of this therapy. Ortho-Shockwave Bilateral Wrists is not medically necessary.

General Ortho consult for left shoulder and right hand: 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)-TWC, Office visits.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, Chapter 7, Independent Medical Examinations and Consultations, page 132.

Decision rationale: According to the MTUS, a referral request should specify the concerns to be addressed in the independent or expert assessment, including the relevant medical and non-medical issues, diagnosis, causal relationship, prognosis, temporary or permanent impairment, workability, clinical management, and treatment options. The medical record lacks sufficient

documentation and does not support a referral request. General Ortho consult for left shoulder and right hand is not medically necessary.

Pain management for cervical and lumbar spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC Office visits.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Chronic Pain Disorder Medical Treatment Guidelines, State of Colorado Department of Labor and Employment, 04/27/2007, pg. 56.

Decision rationale: The California MTUS makes no recommendations regarding referral to a pain management specialist. Alternative guidelines have been referenced. The guidelines state that referral to a pain specialist should be considered when the pain persists but the underlying tissue pathology is minimal or absent and correlation between the original injury and the severity of impairment is not clear. Consider consultation if suffering and pain behaviors are present and the patient continues to request medication, or when standard treatment measures have not been successful or are not indicated. The patient's symptoms do not meet the above criteria. Pain management for cervical and lumbar spine is not medically necessary.

Physical therapy 2x4 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine. Decision based on Non-MTUS Citation ODG-TWC Neck and Upper Back Procedure Summary online version, Low Back, Physical therapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58-60.

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines state that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Continued physical therapy is predicated upon demonstration of a functional improvement. There is no documentation of objective functional improvement. Physical therapy 2x4 weeks is not medically necessary.

Acupuncture 1x4 weeks: Overturned

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The request is for 4 visits of acupuncture. The Chronic Pain Medical Treatment Guidelines allow for initial 4-6 visits after which time there should be documented

functional improvement prior to authorizing more visits. The request for 4 acupuncture visits is in accordance with the MTUS as appropriate to establish whether the treatment is effective. I am reversing the previous utilization review decision. Acupuncture 1x4 weeks is medically necessary.

Anaprox 550mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-73.

Decision rationale: The MTUS recommends NSAIDs at the lowest dose for the shortest period in patients with moderate to severe pain. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence of long-term effectiveness for pain or function. The medical record contains no documentation of functional improvement. Anaprox 550mg #30 is not medically necessary.

Prilosec 20mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Proton pump inhibitors.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, prior to starting the patient on a proton pump inhibitor, physicians are asked to evaluate the patient and to determine if the patient is at risk for gastrointestinal events. Criteria used are: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID. There is no documentation that the patient has any of the risk factors needed to recommend the proton pump inhibitor Omeprazole. Prilosec 20mg is not medically necessary.

Flexeril 7.5mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain). Decision based on Non-MTUS Citation ODG-TWC Pain Procedure Summary.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 64.

Decision rationale: The MTUS Chronic Pain Treatment Guidelines do not recommend long-term use of muscle relaxants such as Cyclobenzaprine. The patient has been taking

Cyclobenzaprine for an extended period, long past the 2-3 weeks recommended by the MTUS. The clinical information submitted for review fails to meet the evidence-based guidelines for the requested service. Flexeril 7.5mg is not medically necessary.

Tramadol ER 150gm: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram) Page(s): 113.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that continued or long-term use of opioids should be based on documented pain relief and functional improvement or improved quality of life. Tramadol is a centrally acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic. Tramadol can be added to the medication regimen, but as the immediate-release oral formulation, not as the extended-release formulation. There is no documentation supporting any functional improvement with the continued long-term use of opioids. Tramadol ER 150gm is not medically necessary.

Compound: Ketoprofen and Flurbiprofen 120gm: Upheld

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

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

Decision rationale: According to the MTUS, there is little to no research to support the use of many of these compounded topical analgesics. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Ketoprofen agent is not currently FDA approved for a topical application. It has an extremely high incidence of photo contact dermatitis. Compound: Ketoprofen and Flurbiprofen 120gm is not medically necessary.