

Case Number:	CM15-0116473		
Date Assigned:	06/30/2015	Date of Injury:	04/08/2015
Decision Date:	09/04/2015	UR Denial Date:	06/09/2015
Priority:	Standard	Application Received:	06/16/2015

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: New York

Certification(s)/Specialty: Pediatrics, Internal 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 57 year old female, who sustained an industrial injury on April 8, 2015. The injury occurred while the injured worker was assisting a co-worker lift a patient. The injured worker experienced a sharp pain in her back and shoulders. Associated symptoms included numbness and tingling radiating down the lower extremities. The injured worker was noted to not be working due to persistent symptoms. The diagnoses have included lumbosacral sprain/strain, rule out lumbosacral spine discogenic disease, bilateral shoulder sprain/strain, bilateral shoulder tendinitis, bilateral knee sprain/strain and rule out bilateral knee internal derangement. Treatment to date has included medications, ice/heat treatments, home exercise program and 12 sessions of physical therapy. Documentation dated May 11, 2015 notes that the injured worker reported 50% improvement with the completed physical therapy sessions but remained symptomatic. Current documentation dated May 21, 2015 notes that the injured worker reported back pain, bilateral shoulder pain and bilateral knee pain. Examination of the lumbar spine revealed diffuse tenderness to palpation, spasms, trigger points of the bilateral paraspinal muscles, decreased range of motion and a positive Kemp's test bilaterally. Examination of the shoulders revealed tenderness to palpation bilaterally, decreased motor strength in the right shoulder and a positive supraspinatus/apprehension testy bilaterally. Examination of the knees revealed bilateral knee swelling, tenderness to palpation and a decreased range of motion. Special orthopedic testing included a positive patellar apprehension, patellofemoral grinding and McMurray test bilaterally. The treating physician's plan of care included requests for Tramadol/ Ultram 50 mg # 60, Trepadone # 120, extracorporeal shockwave therapy to then right

shoulder, hot/cold therapy (rental or purchase), transcutaneous electrical nerve stimulation unit and supplies (rental or purchase), lumbosacral brace, electromyography/nerve conduction velocity study of the bilateral lower extremities, physical therapy # 12 to the lumbar, bilateral knees and bilateral shoulders and a function capacity evaluation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol/ Ultram 50mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

Decision rationale: The Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines state that central acting analgesics may be used to treat chronic pain. This small class of synthetic opioids exhibits opioid activity and a mechanism of action that inhibits the reuptake of serotonin and norepinephrine. Central analgesics drugs such as Tramadol (Ultram) are reported to be effective in managing neuropathic pain. Side effects are similar to traditional opioids. There is no documentation of what prior medications that the IW had tried and the outcome, without this medication, it is not possible to determine the necessity of the request. Therefore, through e request for Tramadol/Ultram 50 mg # 60 is not medically necessary.

Trepadone #120: Upheld

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

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

Decision rationale: The Medical Treatment Utilization Schedule (MTUS) are silent on Trepadone. The Official Disability Guidelines do not recommended Trepadone. Trepadone is a medical food that is suggested for use in the management of joint disorders associated with pain and inflammation. It is a proprietary blend of L-arginine, L-glutamine, L-histidine, choline bitartrate, 5-hydroxytryptophan, L-serine, gamma-aminobutyric acid, grape seed extract, cinnamon bark, cocoa, omega-3 fatty acids, histidine, whey protein hydrolysate, glucosamine, chondroitin and cocoa. The entries for 5-hydroxytryptophan, choline bitartrate, L-arginine, histidine, L-glutamine, L-serine and GABA all indicate there is no role for these supplements as treatment for chronic pain. Current literature suggests omega-3 fatty acids for treatment of certain cardiovascular and lipid conditions, treatment of rheumatoid arthritis and for selected patients for depression (primarily those who are unable to take conventional antidepressants).

There is insufficient evidence to support use for osteoarthritis or for neuropathic pain. Per the Official Disability Guidelines, Trepadone is not recommended for joint disorders, pain and inflammation. Therefore, the request for Trepadone # 120 is not medically necessary.

Extracorporeal shockwave therapy for the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation Official Disability Guidelines, Shoulder.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder - Extracorporeal shock wave therapy (ESWT).

Decision rationale: Per ACOEM guidelines state that there is a recommendation against using extracorporeal shockwave therapy. Per ODG guidelines ESWT is recommended for calcifying tendinitis but not for other shoulder disorders. There is no notation of calcifying tendinitis in the chart; diagnosis for the shoulder is bilateral shoulder sprain/strain. The request is not medically necessary.

Hot/cold therapy unit; rental or purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 13 Knee Complaints Page(s): 203, 338.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299.

Decision rationale: Per ACOEM guidelines, "at-home local applications of cold in first few days of acute complaint; thereafter, applications of heat or cold." There is no notation in the documentation that the IW had tried at home hot and cold packs and the outcome of such treatments. Without the trial of at home packs, the request for a hot/cold therapy unit is not medically necessary.

TENS unit and supplies; rental or purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 12 Low Back Complaints Page(s): 203, 300.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy; TENS, chronic pain (transcutaneous electrical nerve stimulation) Page(s): 114-115.

Decision rationale: Per MTUS guidelines, TENS is not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration

for neuropathic pain, phantom limb pain, spasticity and multiple sclerosis. Several published evidence-based assessments of transcutaneous electrical nerve stimulation (TENS) have found that evidence is lacking concerning effectiveness. The IW has none of the conditions as an indication for TENS use and is not doing physical therapy and thus the request is not medically reasonable and appropriate.

Lumbosacral brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

Decision rationale: According to ACOEM guidelines, lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. The ODG guidelines state that lumbar supports are recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific LBP (very low-quality evidence, but may be a conservative option). The IW has diagnoses of lumbar sprain/strain, which is not an indication for bracing/supports. The request is not medically necessary and appropriate.

EMG/NCV of the bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304.

Decision rationale: According to MTUS guidelines electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. MTUS does not have recommendations regarding NCS. ODG states that EMG is recommended as an option (needle, not surface). EMGs (electromyography) may be useful to obtain unequivocal evidence of radiculopathy, after 1- month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. ODG states that NCS is not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. Due to the request being for both EMG and NCV and no evidence of neurologic deficit on exam the request is not medically reasonable and necessary.

Physical therapy 3 x 4 (lumbar, bilateral knees/shoulders): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-289.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints, Chapter 12 Low Back Complaints, Chapter 13 Knee Complaints Page(s): 204, 287, 337,338. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Lumbar and Thoracic (Acute and Chronic), Shoulder (Acute and Chronic), Knee and Leg (Acute and Chronic).

Decision rationale: The Medical Treatment Utilization Schedule (MTUS), ACOEM Chapters on low back, shoulder and knee pain states that if the treatment with non-prescription analgesic does not adequately relieve symptoms and activity limitations, physical methods can be added. Physical methods include initial and follow-up visits for education counseling and evaluation of home exercise. The ACOEM guidelines on shoulder complaints states that evaluating and managing shoulder complaints through physical treatment methods, activities and exercise is recommended. The Official Disability Guidelines state that physical therapy for a sprain/strain of the shoulder and upper arm allow treatment for frequency of 10 visits over 8 weeks, 10 visits over 5 weeks for a lumbar sprain/strain and 12 visits over 8 weeks for knee sprains/strains. The documentation notes that the injured worker had completed 12 physical therapy sessions with as much as 50% improvement. However, specific documentation regarding the functional improvement was not provided. Therefore, the request for physical therapy # 12 to the lumbar spine, bilateral knees and bilateral shoulders is not medically necessary.

Functional capacity evaluation: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness For Duty - Functional capacity evaluation (FCE).

Decision rationale: Functional capacity evaluation is recommended prior to admission to a Work Hardening (WH) Program, with preference for assessments tailored to a specific task or job. Not recommend routine use as part of occupational rehab or screening, or generic assessments in which the question is whether someone can do any type of job generally. There is no notation in the medical record that the IW was returning to work. The request is not medically necessary and appropriate.