MAXIMUS Federal Services

Case Number:	CM15-0031347		
Date Assigned:	03/26/2015	Date of Injury:	08/13/2013
Decision Date:	05/11/2015	UR Denial Date:	01/23/2015
Priority:	Standard	Application Received:	02/19/2015

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, Arizona
Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 53-year-old female who reported an injury on 08/13/2013 due to an unknown mechanism of injury. The injured worker was evaluated on 03/04/2015. No physical exam findings were documented during that evaluation. The injured worker's treatment plan included topical compounded creams, chiropractic care, acupuncture, a urine drug screen, and a follow up appointment. A request for authorization was submitted on 03/04/2015. The medications included on that form were Anaprox, Prilosec, Flexeril, and tramadol. The clinical documentation submitted for review does indicate that the injured worker was monitored for aberrant behavior with urine drug screens. The injured worker's most recent physical examination was documented on 11/18/2014. It was documented that the injured worker had limited range of motion of the cervical spine with tenderness to palpation of the right upper extremity and tenderness to palpation of the left upper extremity with restricted range of motion of bilateral shoulders. It was noted that the injured worker had undergone shockwave therapy. No justification for the request was provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Acupuncture once a week for four weeks for the Lumbar Spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The requested acupuncture once a week for 4 weeks for the lumbar spine is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends acupuncture as an adjunctive treatment to active therapy to assist with pain control and medication reduction. The clinical documentation does not provide an adequate assessment of the patient to support that there is a need for a passive treatment in conjunction with an active treatment. The clinical documentation does not provide a formal plan of medication reduction in association with the requested treatment. As such, the requested acupuncture once a week for 4 weeks for the lumbar spine is not medically necessary or appropriate.

Chiropractic Therapy Two times a week for four weeks for the Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM,Postsurgical Treatment Guidelines Page(s): 58.

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

Decision rationale: The requested chiropractic therapy 2 times a week for 4 weeks for the lumbar spine is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does recommend the use of chiropractic therapy to assist with pain control and restoration of function of injuries to the lumbar spine. However, the clinical documentation fails to provide any indication that the injured worker has received prior treatment. Therefore, a trial of chiropractic care would be indicated in this clinical situation. However, the California Medical Treatment Utilization Schedule recommends a trial be limited to 3 to 6 treatments to support efficacy of treatment. The request exceeds this recommendation. There are no exceptional factors noted to support extending treatment beyond guideline recommendations. As such, the requested chiropractic therapy 2 times a week for 4 weeks for the lumbar spine is not medically necessary or appropriate.

Shockwave Therapy x 24 (6 sessions for the Cervical Spine, 6 Sessions for the Lumbar Spine, 6 sessions for the Right Ankle, and 6 sessions for the Right Foot): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Peer review literature, Extracorporeal Shock Wave Therapy for Orthopedic Conditions.

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, Shockwave Therapy.

Decision rationale: The requested shockwave therapy x 24 sessions (6 sessions for the cervical spine, 6 sessions for the lumbar spine, 6 sessions for the right ankle, and 6 sessions for the right foot) are not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not address the use of shockwave therapy. The Official Disability Guidelines do recommend continuation of shockwave therapy be based on documented functional benefit and evidence of pain relief. It is also recommended that this type of treatment be used in conjunction with active therapy. The clinical documentation submitted for review does not provide any indication that the injured worker is participating in any type of active therapy. Furthermore, the clinical documentation does indicate that the injured worker has previously participated in shockwave therapy. Significant functional benefit or pain relief resulting from previous treatment was not provided. Therefore, continued treatment would not be supported. As such, the requested shockwave therapy x 24 (6 sessions for the cervical spine, 6 sessions for the lumbar spine, 6 sessions for the right ankle, and 6 sessions for the right foot) are not medically necessary or appropriate.

Sentra AM #60: Upheld

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

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

Decision rationale: The requested Sentra AM #60 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not address medical food. The Official Disability Guidelines do not support the use of medical food as it is not approved by the FDA to treat diagnoses related to chronic pain. The clinical documentation does not provide any support to extend treatment beyond guideline recommendations. Furthermore, the request as it is submitted does not provide any indication of dosage or frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Sentra AM #60 is not medically necessary or appropriate.

Sentra PM #60: Upheld

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

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

Decision rationale: The requested Sentra PM #60 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not address medical food. The

Official Disability Guidelines do not support the use of medical food as it is not approved by the FDA to treat diagnoses related to chronic pain. The clinical documentation does not provide any support to extend treatment beyond guideline recommendations. Furthermore, the request as it is submitted does not provide any indication of dosage or frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Sentra PM #60 is not medically necessary or appropriate.

Gabadone #60: Upheld

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

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

Decision rationale: The requested Gabadone #60 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not address medical food. The Official Disability Guidelines do not support the use of medical food as it is not approved by the FDA to treat diagnoses related to chronic pain. The clinical documentation does not provide any support to extend treatment beyond guideline recommendations. Furthermore, the request as it is submitted does not provide any indication of dosage or frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Gabadone #60 is not medically necessary or appropriate.

Theramine #90: Upheld

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

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

Decision rationale: The requested Theramine #90 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not address medical food. The Official Disability Guidelines do not support the use of medical food as it is not approved by the FDA to treat diagnoses related to chronic pain. The clinical documentation does not provide any support to extend treatment beyond guideline recommendations. Furthermore, the request as it is submitted does not provide any indication of dosage or frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Theramine #90 is not medically necessary or appropriate.

Flurbiprofen 120gm #1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

Decision rationale: The requested flurbiprofen 120 gm #1 is not medically necessary or appropriate. The California MTUS Schedule does not recommend the use of nonsteroidal anti-inflammatory drugs for patients who experience spine pain. The clinical documentation does support that the injured worker has cervical and lumbar spine pain. The request as it is submitted does not specifically identify an applicable body part. Therefore, it could be assumed that the injured worker will use this medication for spine pain. As this is not supported by guideline recommendations and there are no exceptional factors to support extending treatment beyond guideline recommendations, the use of this medication is not supported. As such, the request for flurbiprofen 120 gm #1 is not medically necessary or appropriate.

Ketoprofen 120gm #1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

Decision rationale: The requested ketoprofen 120 gm #1 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not support the use of ketoprofen to treat neuropathic pain as it not FDA approved as a topical agent. The clinical documentation does not provide any exceptional factors to support extending treatment beyond guideline recommendations. Additionally, the request as it is submitted does not identify an applicable body part. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested ketoprofen 120 gm #1 is not medically necessary or appropriate.

Protonix 20mg #60: Upheld

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

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

Decision rationale: The requested Protonix 20 mg #60 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule supports the use of gastrointestinal protectants for patients who are risk for developing gastrointestinal events related

to medication usage. The clinical documentation submitted for review does not provide any indication that the injured worker is at risk for developing gastrointestinal events related to medication use. There is no assessment of the patient's gastrointestinal system provided within the documentation. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. As such, the requested Protonix 20 mg #60 is not medically necessary or appropriate.

Fexmid 7.5mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter, Non-sedating muscle relaxants.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

Decision rationale: The requested Fexmid 7.5 mg #90 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule does not support the long term use of muscle relaxants in the management of chronic pain. The clinical documentation submitted for review does indicate that the injured worker has been on this medication since at least 11/2014. This exceeds guideline recommendations. There are no exceptional factors noted to support extending treatment beyond guideline recommendations. Additionally, the clinical documentation does not provide an adequate pain assessment of the patient to support continued use. There is no documentation of functional benefit within the submitted documentation. Furthermore, the request as it is submitted does not identify a frequency of treatment. In the absence of this information, the appropriateness and the request cannot be determined. As such, the requested Fexmid 7.5 mg #90 is not medically necessary or appropriate.

Tramadol ER 150mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines On-Going Management, Opioids Page(s): 78-80, 81. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter, Opioids.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management Page(s): 78.

Decision rationale: The requested tramadol ER 150 mg #30 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends the continued use of opioids and the management of chronic pain be supported by documentation of pain assessment to support efficacy, documentation of functional benefit, managed side effects, and evidence that the patient is compliant with prescribed medications. The clinical documentation submitted for review does indicate that the injured worker is monitored with urine drug screens and is not at risk for nonadherent behavior. The clinical documentation submitted for review does not provide an adequate assessment of pain relief for functional benefit to support continued

use of this medication. Additionally, the request as it is submitted does not provide a frequency of treatment. In the absence of this information, the appropriateness of the request cannot be determined. As such, the requested tramadol ER 150 mg #30 is not medically necessary or appropriate.