

Case Number:	CM15-0040879		
Date Assigned:	03/11/2015	Date of Injury:	07/27/2014
Decision Date:	06/26/2015	UR Denial Date:	02/09/2015
Priority:	Standard	Application Received:	03/03/2015

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 (IW) is a 21-year-old male, who sustained an industrial injury on 7/27/2014. He was diagnosed as having right wrist sprain/strain, rule out right carpal tunnel syndrome, lumbago, and lumbar spine sprain/strain rule out disc displacement and rule out lumbar radiculopathy. Treatment to date has included medications, physical therapy, acupuncture, chiropractic, shock wave therapy, diagnostics and consultation with pain management specialist. Per the Primary Treating Physician's Progress Report dated 2/05/2015, the injured worker reported constant, moderate to severe burning right wrist pain rated as 5-6/10. He reported constant, moderate to severe burning radicular low back pain with muscle spasms rated as 7/10. There was numbness and tingling of the bilateral lower extremities. Medications offer temporary relief and improve his ability to have restful sleep. Physical examination revealed tenderness to palpation of the carpals and the thenar eminence. Range of motion of the right wrist was decreased. There was palpable tenderness with spasms of the lumbar paraspinal muscles with restricted range of motion of the lumbar spine. The plan of care included medications, physical therapy, acupuncture and shock wave therapy. Authorization was requested for physical therapy for the right wrist, hand, and lumbar spine (3x6), acupuncture, chiropractic for the right wrist, hand, and lumbar spine, shockwave therapy x 3 treatments, Ketoprofen, Cyclobenzaprine, Tabradol, Deprizine, Dicopanil, and Fanatrex.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy for the Right Wrist/Hand and Lumbar Spine (18-sessions, 3 times a week for 6 weeks): Upheld

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

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, Forearm, Wrist, & Hand Chapters.

Decision rationale: According to the Official Disability Guidelines, physical therapy is recommended as an option as follows. Lumbar sprains and strains 10 visits over 8 weeks. Wrist sprains/strains 9 visits over 8 weeks. There is documentation that the IW had prior therapy but there were no recent notes documenting response to treatment or a rationale for further visits beyond the recommended course. Therefore, the request is not medically necessary and appropriate.

Acupuncture for the Right Wrist/Hand and Lumbar Spine (18-sessions, 3 times a week for 6 weeks): Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation Acupuncture for the Right Wrist/Hand and Lumbar Spine (18-sessions, 3 times a week for 6 weeks).

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) .

Decision rationale: According to the Acupuncture Medical Treatment Guidelines, acupuncture is used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. According to the Official Disability Guidelines acupuncture is not recommended for the wrist, with regards to the low back acupuncture is recommended as an option for chronic low back pain using a short course of treatment in conjunction with other interventions. For the low back initial trial of 3-4 visits over 2 weeks and then with evidence of objective functional improvement, total of up to 8-12 visits over 4-6 weeks. The documentation notes that the IW should continue acupuncture however there were no notes from previous visits or functional improvement with acupuncture. Additionally, the IW is not currently reducing pain medication or intolerant of pain medication according to documentation. Therefore, the request is not medically necessary and appropriate.

Chiropractic Treatment for the Right Wrist/Hand and Lumbar Spine (18-sessions, 3 times a week for 6 weeks): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 58-60. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chiropractic Care.

Decision rationale: Chronic Pain Medical Treatment Guidelines, chiropractic care is recommended for chronic pain if caused by musculoskeletal conditions. With regards to the low back, a therapeutic trial of 6 visits over 2 weeks, with evidence of objective functional improvement. At the end of the trial, there should be a formal assessment whether the treatment is continuing to produce satisfactory clinical gains. The documentation notes that the IW should continue chiropractic care however there were no notes from previous visits nor noted functional improvement with chiropractic care. With regards to the wrist, the Official Disability Guidelines state that chiropractic care is not recommended. Therefore, the request is not medically necessary and appropriate.

Shock Wave Therapy (3-treatments): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

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

Decision rationale: MTUS and ODG guidelines do not comment on shockwave therapy for the low back and wrist. ODG guidelines for the elbow state that ESWT is not recommended. If the decision is made to use this treatment despite the lack of convincing evidence, criteria for use are that the condition has remained despite six months of standard treatment, at least three conservative treatments have been performed prior to use of ESWT. These would include: (a) Rest; (b) Ice; (c) NSAIDs; (d) Orthotics; (e) Physical Therapy; (e) Injections (Cortisone), maximum of 3 therapy sessions over 3 weeks and contraindications are patients with blood clotting diseases, infections, tumors, cervical compression, arthritis of the spine or arm, or nerve damage; Patients with cardiac pacemakers; Patients who had physical or occupational therapy within the past 4 weeks; Patients who received a local steroid injection within the past 6 weeks; Patients with bilateral pain; Patients who had previous surgery for the condition. According to the documentation, the IW was undergoing physical therapy. Therefore, the request is not medically necessary and appropriate.

Ketoprofen 20% Cream, 167 grams (apply a thin layer to affected area 3 times a day):
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics - Non-Steroidal Anti-Inflammatory Drugs (NSAIDs).

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

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, topical NSAIDs are indicated for treatment of osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment. They are recommended for short-term use. Guidelines also state that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Ketoprofen is not FDA approved for topical use. Therefore, the request is not medically necessary and appropriate.

Cyclobenzaprine 5% Cream, 110 grams (apply a thin layer to affected area 3 times a day): Upheld

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

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

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Cyclobenzaprine is not FDA approved for topical use. Therefore, the request is not medically necessary and appropriate.

Synapryn 10mg/1ml, 500ml oral suspension (take 1 tsp 3 times a day): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use, On-Going Management Page(s): 78. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Insomnia Treatment.

Decision rationale: The IW is documented to be on an opioid, Synapryn, for pain relief. Documentation did not include review and documentation of pain relief, functional status, appropriate medication use, and side effects. According to the Chronic Pain Medical Treatment Guidelines, pain assessment should include: current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts. Satisfactory response to treatment may be indicated by the patient's decreased pain, increased level of function, or improved quality of life. Therefore, the request is not medically necessary and appropriate.

Tabradol 1mg/ml, 250ml oral suspension (take 1 tsp 2-3 times a day): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain) Page(s): 63-65.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, Tabradol (cyclobenzaprine) is recommended for a short course of therapy. Limited, mixed-evidence does not allow for a recommendation for chronic use. The greatest effect appears to be in the first 4 days of treatment. The documentation does reference muscle spasm that the Flexeril would be used for however at this time frame it is not indicated. Therefore, the request is not medically necessary and appropriate.

Deprizine 15mg/ml, 250ml oral suspension (take 2 tsp once daily): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69.

Decision rationale: Chronic Pain Medical Treatment Guidelines it is necessary to determine if the patient is at risk for gastrointestinal events. Risk factors 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 (e.g., NSAID + low-dose ASA). A history of ulcer complications is the most important predictor of future ulcer complications associated with NSAID use. There was no notation of GI symptoms or a history of risk factors. Therefore, the request is not medically necessary and appropriate.

Dicopanol 5mg/ml, 150ml oral suspension (take 1ml by mouth at bedtime): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines, Compound Drugs.

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

Decision rationale: According to the Official Disability Guidelines, pharmacological agents for insomnia should only be used after careful evaluation of potential causes of sleep disturbance for the etiology. There is no discussion of an investigation into the origin of the sleep disturbance and non-pharmacological interventions that may have been utilized. Sedating antihistamines have been suggested for sleep aids, tolerance seems to develop within a few days. Prolonged use is not recommended. There was no documentation of objective functional benefit with prior use of these medications. Therefore, the request is not medically necessary and appropriate.

Fanatrex 25mg/ml, 420ml oral suspension (take 1 tsp three times a day): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines, Compound Drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy Drugs (AEDs) Specific Anti-Epilepsy Drugs Page(s): 18-19.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, Fanatrex (gabapentin) is recommended on a trial basis with lumbar spinal stenosis to assess if there is improved sensation, decreased pain with movement and increased walking distance. There was no documentation of objective functional benefit with prior use of these medications or a radiculopathy. Therefore, the request is not medically necessary and appropriate.