

Case Number:	CM15-0109575		
Date Assigned:	07/31/2015	Date of Injury:	10/16/2009
Decision Date:	10/07/2015	UR Denial Date:	05/15/2015
Priority:	Standard	Application Received:	06/05/2015

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, California
 Certification(s)/Specialty: Emergency 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 59 year old female, who sustained an industrial injury on 10/16/2009. She has reported subsequent headaches, neck and knee pain and was diagnosed with sprains and strains of the sacroiliac region and back and lumbar spinal stenosis. The injured worker was also noted to have dermatitis. Treatment to date has included medication. Documentation shows that Protopic, Clobetasol and Ultram were prescribed since at least 04-11-2014. It's unclear as to when Gabapentin was started but a progress note on 04-30-2015 indicates that a refill was being requested so the medication was taken prior to this date. In a progress note dated 04-30-2015, the injured worker reported headaches and allergic dermatitis symptoms of the back and hands. The injured worker also reported numbness and tingling in the right arm. Objective findings were notable for dermatitis of the lumbar area, dermatitis in both hands, bilateral cuff weakness of the shoulder. Tinel's test over the carpal tunnel on the right was noted to be negative. Work status was documented as permanent and stationary. A request for authorization of neurology consult, Ultram (dose and quantity unspecified), Gabapentin (dose and quantity unspecified), Protopic (dose and quantity unspecified), Clobetasol (dose and quantity unspecified), retro lumbar support (dose and quantity unspecified) and retro wrist support (dose and quantity unspecified) was submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Neurology Consult: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, and Shoulder Complaints 2004, and Elbow Complaints 2007, and Forearm, Wrist, and Hand Complaints 2004, and Low Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Physical Examination, Diagnostic Criteria, and Shoulder Complaints 2004, Section(s): Medical History, Physical Examination, Diagnostic Criteria, and Low Back Complaints 2004, Section(s): Physical Examination, Diagnostic Criteria. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) Chapter, Office Visits.

Decision rationale: As per ACOEM guidelines for the neck, shoulder and low back, evidence of severe neurologic compromise that correlates with the medical history and test results may indicate a need for immediate consultation. As per ODG, the need for evaluation and management visits to physicians is individualized based on a review of the patient concerns, signs and symptoms, clinical stability and physician judgment. The determination for medical necessity of an office visit requires individualized case review and assessment. The most recent progress note submitted showed subjective complaints of headache and numbness and tingling of the right arm. The objective findings showed negative Spurling's sign of the neck and there were no other neurological examination findings documented. There were no red flags of severe neurologic compromise and insufficient physical examination findings documented to support the need for neurology consultation. It is unclear from the documentation what condition was being considered with the request for the consultation. Without the support of the documentation and guidelines, the request for neurology consultation is not medically necessary.

Ultram (dose & quantity unspecified): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Work Loss Data Institute, Official Disability Guidelines Treatment in Workers Compensation, 7th Edition, 2011 Tramadol.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use, Opioids for chronic pain.

Decision rationale: As per CA MTUS guidelines, in order to justify the long term usage of opioid medication, there must be documentation of the most and least amount of pain, average amount of pain, appropriate medication usage and side effects and a good response to treatment can be shown by "decreased pain, increased function or improved quality of life." The medical documentation submitted is minimal and there is no documentation of the severity of the injured worker's pain, the effectiveness of the medication, any discussion of side effects or evidence of monitoring for potential drug misuse or dependence. Ultram had been prescribed since at least 04-11-2014. There is also no documentation of objective functional improvement or significant pain reduction with use of this medication as there was no change in work status or documentation of improved quality of life and no indication that the injured worker's pain

had improved with use of the medication. In addition, there was no documentation of the frequency, dosage or instructions for use of the medication in the most recent progress note or the request. Therefore, the request for authorization of Ultram is not medically necessary.

Gabapentin (dose & quantity unspecified): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs).

Decision rationale: As per CA MTUS guidelines, anti-epilepsy drugs are recommended for neuropathic pain. A good response has been defined as 50% reduction in pain and a moderate response has been defined as a 30% reduction in pain. Gabapentin has been shown as effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and is considered a first line treatment for neuropathic pain. As per MTUS, "after initiation of treatment there should be documentation of pain relief and improvement in function as well as documentation of side effects incurred with use. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects." It's unclear as to when Gabapentin was started but documentation submitted shows that it had been prescribed prior to 04-30-2015. There was no documentation of significant pain reduction, objective functional improvement or improved quality of life with use of this medication. There was no documentation of a change in work status, improved quality of life or significant improvement of pain. Additionally, there was no documentation of the frequency, dosage or instructions for use of the medication in the most recent progress note or the request. Therefore, the request for authorization of Gabapentin is not medically necessary.

Protopic (dose & quantity unspecified): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation www.drugs.com/protopic.html.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.fda.gov/Drugs/DrugSafety/PostmarketDrugSafetyInformationforPatientsandProviders/ucm107845.htm>, <http://www.uptodate.com/contents/tacrolimus>.

Decision rationale: Ca MTUS and ODG are silent on this topic. The above referenced guidelines discuss this medication. It is an agent used in the treatment of eczema. The documentation supports the IW has been prescribed medication for a minimum of 6 months. There is no documentation to indicate the IW's response to this medication. The IW is described as having "dermatitis." This is a generic term meaning inflammation of the skin. The requested medication is specific for the treatment of eczema which is inflammation of the skin usually caused from allergens. Additionally, the request does not include the location and frequency of medication application. Without further information and supporting documentation, the request for protopic is not medically necessary.

Clobetasol (dose & quantity unspecified): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation www.webmd.com/drugs/2/drug-4403-723/clobetasol-top/clobetasol-topical/details#interactions.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.guideline.gov/content.aspx?id=12626&search=clobetasol>.

Decision rationale: Ca MTUS and ODG are silent on this topic. The above referenced guidelines discuss this medication. It is topical steroid agent used in the treatment of eczema and psoriasis. The documentation supports the IW has been prescribed medication for a minimum of 6 months. There is no documentation to indicate the IW's response to this medication. The IW is described as having "dermatitis." This is a generic term meaning inflammation of the skin. The requested medication is specific for the treatment of eczema and psoriasis which is inflammation of the skin usually caused from allergens or autoimmune conditions. Additionally, the request does not include the location and frequency of medication application. Without further information and supporting documentation, the request for Clobetasol is not medically necessary.

Retro Lumbar Support (Retro date unspecified): 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); Treatment Protocols, 5th Edition.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Initial Care, Physical Methods. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back (Acute and Chronic) Chapter, Lumbar Supports.

Decision rationale: As per ACOEM guidelines, "lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief." As per ODG, lumbar supports are not recommended for prevention but are recommended as an option for treatment of compression fracture, spondylolisthesis, documented instability and for treatment of non-specific low back pain. The documentation submitted is insufficient to support the medical necessity of lumbar supports. There was no documentation of compression fractures, spondylolisthesis or documented instability, nor was there documentation of low back pain in the progress notes. Objective findings were minimal and the only notable finding of the lumbar spine documented was the presence of dermatitis. Therefore, the request is not medically necessary.

Retro Wrist Support (Retro date unspecified): Upheld

Claims Administrator guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Initial Care, Physical Methods. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, & Hand (Acute & Chronic) Chapter, Splints.

Decision rationale: As per ACOEM guidelines, splinting may be used as a first line conservative treatment in the management of forearm, wrist and hand complaints for carpal tunnel syndrome, de Quervain's, strains, etc. As per ODG, splinting is recommended for treating displaced fractures, arthritic pain and hand pain. There was no documentation of any wrist complaints or a diagnosis of any condition involving the wrist. The objective examination findings in the most recent progress notes showed dermatitis of the hand and Tinel's sign over the right wrist was negative. There is insufficient documentation to support the medical necessity of wrist supports. Therefore, the request for authorization of wrist supports is not medically necessary.