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| Case Number: | CM15-0123516 | | |
| Date Assigned: | 07/14/2015 | Date of Injury: | 10/27/2014 |
| Decision Date: | 10/08/2015 | UR Denial Date: | 06/12/2015 |
| Priority: | Standard | Application Received: | 06/26/2015 |

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 69 year old male, who sustained an industrial injury on 10/27/14. Initial complaints were not reviewed. The injured worker was diagnosed as having cervical sprain/strain; left shoulder sprain/strain; left shoulder rotator cuff tear. Treatment to date has included physical therapy; injection; medications. Diagnostics studies included MRI cervical spine with Flex-Ext (4/16/15). Currently, the PR-2 notes dated 5/19/15 indicated the injured worker complains of pain in his neck rated in severity as 6/10 and pain in left shoulder rated also as 6/10. The left shoulder range of motion notes some limitations. A MRI of the cervical spine dated 4/16/15 with flexion and extension demonstrates an impression of congenital narrowing of the spinal canal that contributes to spinal canal stenosis from C3-C4 through C7-T1. And degenerative discogenic spondylosis is seen from C4-C5 through C6-C7 with broad-based central disc protrusions abutting the ventral aspect of the cervical spinal cord throughout each level. The provider then included his treatment plan that recommends an orthopedic consult regarding the left shoulder and medications and shockwave therapy. The provider is requesting authorization of Retrospective: shockwave therapy - left shoulder (DOS 4/21/15, 5/12/15, and 5/19/15); Retrospective: shockwave therapy - cervical spine (DOS 5/26/15 and 6/2/15); Shockwave therapy - cervical spine, four treatments after 6/2/15; pain management consultation for cervical spine; Naprosyn 550mg (unknown quantity); Prilosec 20mg (unknown quantity); Flexeril 10mg (unknown quantity); Tramadol 50mg (unknown quantity); Gabapentin 300mg (unknown quantity); Compounded topical cream: Gabapentin 15%, Amitriptyline 4%,

Dextromethorphan 10%, 180 gm and Compounded topical cream: Cyclobenzaprine 2%, Flurbiprofen 25%, 180 gm.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective: shockwave therapy - left shoulder (DOS 4/21/15, 5/12/15, and 5/19/15): Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004.

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

Decision rationale: The ODG note that extracorporeal shock wave therapy is recommended for patients whose pain from calcifying tendinitis of the shoulder has remained despite six months of standard treatment. Within the submitted documentation, there is no specific mention of failure to physical therapy, nor is there a diagnosis of calcific tendinitis. There is mention of rotator cuff strain, but without clarification of the goals of treatment, the diagnosis for which the shockwave therapy is being utilized, and failure of conservative modalities such as NSAIDs, orthotics, and/or physical therapy, this request is not medically necessary.

Retrospective: shockwave therapy - cervical spine (DOS 5/26/15 and 6/2/15): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The ODG note that extracorporeal shock wave therapy is recommended for patients whose pain from calcifying tendinitis of the shoulder has remained despite six months of standard treatment. Within the submitted documentation, there is no specific mention of failure to physical therapy, nor is there a diagnosis of calcific tendinitis. ODG states that shockwave therapy is not recommended for spinal disorders. There is no documentation of extenuating factors to warrant non-adherence to guideline criteria. As such, this request is not medically necessary.

Shockwave therapy - cervical spine, four treatments after 6/2/15: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The ODG note that extracorporeal shock wave therapy is recommended for patients whose pain from calcifying tendinitis of the shoulder has remained despite six months of standard treatment. Within the submitted documentation, there is no specific mention of failure to physical therapy, nor is there a diagnosis of calcific tendinitis. ODG states that shockwave therapy is not recommended for spinal disorders. There is no documentation of extenuating factors to warrant non-adherence to guideline criteria. As such, this request is not medically necessary.

Pain management consultation for cervical spine: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The CA MTUS and the ODG guidelines recommend that patients can be referred to consultation with a pain specialist when the diagnosis is complex or when additional expertise will be beneficial to the medical management. In this clinical setting, the injured worker has had chronic neck pain with history of rotator cuff tear, and spondylotic changes on imaging not responding to conservative treatment, to date. A Pain specialist to optimize medications and function is reasonable in this setting. Therefore the request is medically necessary.

Naprosyn 550 mg (unknown quantity): 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): NSAIDs (non-steroidal anti-inflammatory drugs).

Decision rationale: As per MTUS Chronic Pain Guidelines, NSAIDs are useful for osteoarthritis related pain. Due to side effects, and risks of adverse reactions, MTUS recommends as low a dose as possible for as short a course as possible. Acetaminophen should be considered initial therapy in those with mild to moderate osteoarthritic pain. Within the request itself, there is an unknown quantity for the Naproxen being requested. Also, the injured worker's primary issue is spondylosis and shoulder strain with history of rotator cuff tear; there is no mention of osteoarthritis affecting functional mobility and/or ADLs. As such, this request is not medically necessary.

Prilosec 20 mg (unknown quantity): 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): NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: According to the MTUS Chronic Pain Guidelines, Proton Pump Inhibitors are used to treat symptoms of gastritis, peptic ulceration, acid reflux, and/or dyspepsia related to non-steroidal anti-inflammatories (NSAIDs). There is no mention within the submitted documentation of the injured worker having a high risk for gastrointestinal events. The quantity for the requested Prilosec was not provided. As such, this request is not medically necessary.

Flexeril 10 mg (unknown quantity): Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

Decision rationale: CA MTUS Chronic Pain Treatment Guidelines note that long-term use of muscle relaxants is not recommended. It is associated with mental and physical impaired abilities and has limited efficacy. The injured worker is 69 years old, with chronic pain and long-term use of Flexeril is not recommended per applicable guidelines. There is no quantity within the submitted request. This request at present time is not medically necessary.

Tramadol 50 mg (unknown quantity): 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): Opioids, criteria for use.

Decision rationale: The CA MTUS Chronic Pain Medical Treatment Guidelines state that Tramadol is not recommended as a first line oral analgesic. Furthermore, documentation of the 4 A's including analgesia, adverse events, aberrant behavior, and activities of daily living is required to support ongoing use of opiates. Within the submitted documentation, the 4 A's as it pertains to Tramadol was not specifically outlined. Quantity was not given with the request. As such, this request is not medically necessary.

Gabapentin 300 mg (unknown quantity): 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: The Chronic Pain Medical Treatment Guidelines state that antiepilepsy drugs are recommended for neuropathic pain. They go on to state that a good outcome is defined as 50% reduction in pain and a moderate response is defined as 30% reduction in pain. 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. There is no mention within the submitted documentation of pain, functional, or objective response with Gabapentin use. Furthermore, quantity was not provided with the request. The request is not medically necessary and has not yet been established.

Compounded topical cream: Gabapentin 15%, Amitriptyline 4%, Dextromethorphan 10%, 180 gm: 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): Topical Analgesics.

Decision rationale: Per MTUS guidelines, the use of topical analgesics in the treatment of chronic pain is largely experimental, and when used, is primarily recommended for the treatment of neuropathic pain when trials of first line treatments such as anti-convulsants and/or anti-depressants have failed. The guidelines go on to state that when any compounded product contains 1 medication that is not recommended, the compounded product as a whole is not recommended. Within the submitted documentation, there is no mention of failure to first line traditional oral agents, and specific mention of why topical analgesics are necessary over oral agents. This request is for a topical agent that includes Gabapentin, Amitriptyline, and Dextromethorphan. Gabapentin is not recommended for topical use. This request is not medically necessary.

Compounded topical cream: Cyclobenzaprine 2%, Flurbiprofen 25%, 180 gm: 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): Topical Analgesics.

Decision rationale: Per MTUS guidelines, the use of topical analgesics in the treatment of chronic pain is largely experimental, and when used, is primarily recommended for the treatment

of neuropathic pain when trials of first line treatments such as anti-convulsants and/or anti-depressants have failed. The guidelines go on to state that when any compounded product contains 1 medication that is not recommended, the compounded product as a whole is not recommended. Within the submitted documentation, there is no mention of failure to first line traditional oral agents, and specific mention of why topical analgesics are necessary over oral agents. This request is for a topical agent that includes Cyclobenzaprine, which is not recommended for topical use. The request is not medically necessary and has not been established.