

Case Number:	CM13-0010899		
Date Assigned:	09/26/2013	Date of Injury:	01/01/1994
Decision Date:	02/05/2014	UR Denial Date:	07/25/2013
Priority:	Standard	Application Received:	08/14/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation and is licensed to practice in California. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 47-year-old female who reported an injury on 08/05/1999. The patient is currently diagnosed as status post arthroscopic subacromial decompression of the left shoulder, status post arthroscopic subacromial decompression in the right shoulder, bilateral upper extremity overuse tendonitis, C5-6 disc herniation with radiculopathy, lumbar sprain and strain, and fibromyalgia. The patient was seen by [REDACTED] on 05/31/2013. Physical examination of the cervical spine revealed tenderness to palpation, mildly positive head compression testing, decreased sensibility, and diminished sensation in the C6 distribution and some anterior capsular tenderness. The patient was given an intramuscular injection consisting of a vitamin B complex. Treatment recommendations included continuation of current medication, a request for acupuncture therapy, and an MRI of the cervical spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fluriflex 15/10%: Upheld

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

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

Decision rationale: California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug that is not recommended is not recommended as a whole. As per the clinical notes submitted, there is no evidence of a failure to respond to first line oral medication prior to the initiation of a topical analgesic. The patient has continuously utilized this medication. However, the patient continues to report cervical spine and bilateral shoulder discomfort. Satisfactory response to treatment has not been indicated. Based on the clinical information, the request is non-certified.

TgHot 8/10/2/2/0.05% cream 180 mg: Upheld

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

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

Decision rationale: California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug that is not recommended is not recommended as a whole. As per the clinical notes submitted, there is no evidence of a failure to respond to first line oral medication prior to the initiation of a topical analgesic. The patient has continuously utilized this medication. However, the patient continues to report cervical spine and bilateral shoulder discomfort. Satisfactory response to treatment has not been indicated. Based on the clinical information, the request is non-certified.

. Acupuncture therapy: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: California MTUS Guidelines state acupuncture is used as an option when pain medication is reduced or not tolerated, and it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. The time to produce functional improvement includes 3 to 6 treatments with a frequency of 1 to 3 times per week. As per the clinical notes submitted, the patient has previously undergone acupuncture therapy. Documentation of the previous course of therapy with treatment duration and efficacy was not provided for review. Furthermore, the patient's latest physical examination only revealed tenderness to palpation with slightly diminished sensation in the C6 distribution. Documentation of a significant musculoskeletal deficit was not provided. Based on the clinical information received, the request is non-certified.

MRI scan of the cervical spine: 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), Neck and Upper Back Chapter, Magnetic resonance Imaging (MRI).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back Chapter, Magnetic Resonance Imaging (MRI).

Decision rationale: California MTUS/ACOEM Practice Guidelines state criteria for ordering imaging studies include the emergence of a red flag, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery, or for clarification of the anatomy prior to an invasive procedure. As per the clinical notes submitted, the patient does not currently meet criteria for an MRI scan of the cervical spine. There is no documentation of a failure to respond to recent conservative therapy. There was no significant change in the patient's clinical examination findings that would warrant the need for an imaging study. Based on the clinical information received, the request is non-certified.

Vitamin B12 complex IM: 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) Pain Chapter, Vitamin B.

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

Decision rationale: Official Disability Guidelines state vitamin B is not recommended. Vitamin B is frequently used for treating peripheral neuropathy but its efficacy is not clear. As per the clinical notes submitted, there is no evidence of a vitamin B deficiency that would support the use of supplementation. The medical necessity has not been established. Therefore, the request is non-certified.