

Case Number:	CM13-0045094		
Date Assigned:	12/27/2013	Date of Injury:	07/26/2013
Decision Date:	02/27/2014	UR Denial Date:	10/09/2013
Priority:	Standard	Application Received:	10/31/2013

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 40-year-old female who reported an injury on 07/26/2013. The mechanism of injury was not provided for review. The patient's most recent clinical examination included objective pain complaints of the neck, mid and upper back, lower back, bilateral shoulders/arms, bilateral elbows/forearms, bilateral hips/thighs, bilateral knees, and bilateral ankles/feet. It was noted that the patient complained of numbness in the bilateral hands and wrists. Evaluation of the cervical spine revealed tenderness to palpation over the paraspinal musculature with restricted range of motion and a positive compression test. Evaluation of the thoracic spine revealed tenderness to palpation with restricted range of motion. Evaluation of the lumbar spine revealed tenderness to palpation with restricted range of motion and a positive straight leg raising test bilaterally. Evaluation of the bilateral shoulders revealed tenderness to palpation and restricted range of motion of both shoulders. Evaluation of the bilateral arms revealed tenderness to palpation with restricted range of motion. Evaluation of the bilateral elbows, forearms, wrists, and hands revealed tenderness to palpation with restricted range of motion. Evaluation of the bilateral knees revealed tenderness to palpation. Evaluation of the bilateral ankles revealed tenderness to palpation. Evaluation of the bilateral feet revealed tenderness to palpation. The patient's diagnoses included cervical spine musculoligamentous sprain/strain with radiculitis, thoracic spine strain/sprain, lumbar spine strain/sprain with radiculitis, bilateral shoulder impingement, bilateral elbow lateral epicondylitis, bilateral wrist sprain/strain due to chronic overuse, bilateral hip sprain/strain, bilateral knee sprain/strain, bilateral ankle sprain/strain with plantar fasciitis, and depression and anxiety. The patient's treatment plan included Fluriflex 180 gm, TGHOT 180 gm, tramadol, a urine toxicology screening, and continuation of physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 2 x 6: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation (ACOEM) Pain, Suffering, and the Restoration of Function Chapter, pg. 114; Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine. Page(s): 98-99..

Decision rationale: The Physician Reviewer's decision rationale: The requested physical therapy 2 x 6 is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the patient is currently participating in physical therapy that subjectively provides functional improvement. The clinical documentation submitted for review does not provide any quantitative objective measures to support significant functional benefit from prior therapy. Therefore, continuation of this treatment modality would not be recommended. The California Medical Treatment and Utilization Schedule does recommend the use of physical therapy for up to 8 to 10 visits. As the clinical documentation does not clearly identify the number of visits the patient has previously participated in, the need to continue physical therapy cannot be determined. As such, the requested physical therapy 2 x 6 is not medically necessary or appropriate.

Fluriflex, TGHOT, Tramadol 50mg, # 60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics and Opioids. Page(s): 111 and 74.. Decision based on Non-MTUS Citation Effectiveness of topical administration of opioids in palliative care: a systematic review; B LeBon, G Zeppetella, IJ Higginson - Journal of pain and symptoms, 2009 - Elsevier.

Decision rationale: The Physician Reviewer's decision rationale: The requested Fluriflex, TGHOT, Tramadol 50mg, #60 is not medically necessary or appropriate. The requested medication is a topical compounded medication containing flurbiprofen and cyclobenzaprine. The clinical documentation submitted for review does not provide any evidence that the patient is intolerant of oral formulations of non-steroidal anti-inflammatory drugs. The California Medical Treatment and Utilization Schedule recommends the use of topical non-steroidal anti-inflammatory drugs for patients who are intolerant of oral formulations or when oral formulations are contraindicated for the patient. Additionally, the California Medical Treatment and Utilization Schedule does not recommend the use of cyclobenzaprine as a topical analgesic as there is no scientific evidence to support the efficacy and safety of this type of medication. The California Medical Treatment and Utilization Schedule states that any compounded medication that contains at least 1 drug or drug class that is not recommended by Guideline

recommendations is not supported. Therefore, the continued use of Fluriflex would not be indicated. The requested TGHOT is a compounded medication that contains tramadol/gabapentin/menthol/camphor/capsaicin. The California Medical Treatment and Utilization Schedule recommends the use of capsaicin as a topical agent when the patient is intolerant or fails to respond to other treatments. The clinical documentation submitted for review does not provide any evidence that the patient is intolerant or has failed to respond to other treatments. Additionally, the California Medical Treatment and Utilization Schedule does not recommend the use of gabapentin as a topical analgesic, as there is no scientific evidence to support safety and efficacy of this medication as a topical agent. Peer-reviewed literature does not recommend opioids such as tramadol as a topical analgesic, as there is no scientific evidence to support its use. Therefore, the continued use of this medication would not be indicated. Regarding the use of tramadol 50 mg #60, this medication is not indicated. The California Medical Treatment and Utilization Schedule does not recommend the use of opioids as a first line treatment. The clinical documentation submitted for review does not provide any evidence that the patient has failed to respond to over-the-counter medications or other first line medications such as acetaminophen. Therefore, the use of tramadol 50 mg #60 is not indicated. As such, the requested Fluriflex, TGHOT, Tramadol 50mg, #60 is not medically necessary or appropriate.

ESWT bilateral feet.: 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).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Ankle and Foot Chapter, Extracorporeal shock wave therapy (ESWT).

Decision rationale: The Physician Reviewer's decision rationale: The requested ESWT bilateral feet is not medically necessary or appropriate. The Official Disability Guidelines do recommend the use of extracorporeal shockwave therapy for patients diagnosed with plantar fasciitis who have failed to respond to at least 3 attempts at conservative treatment. The clinical documentation submitted for review does not provide any evidence that the patient has failed to respond to previous attempts at conservative treatment. Therefore, the use of this type of therapy would not be supported. As such, the requested ESWT bilateral feet is not medically necessary or appropriate.

Magnetic resonance imaging (MRI) C/S and L/S.: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-180.. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 177-179; 303-305..

Decision rationale: The Physician Reviewer's decision rationale: The requested magnetic resonance imaging (MRI) C/S and L/S is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine recommends the use of an MRI to clearly identify pathology of neurological deficits. The clinical documentation submitted for review does not provide any evidence that the patient has any upper extremity or lower extremity neurological deficits. Therefore, the use of magnetic resonance imaging for the cervical spine and lumbar spine is not medically necessary or appropriate.

Urine toxicology: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 43..

Decision rationale: The Physician Reviewer's decision rationale: The requested Urine toxicology is not medically necessary or appropriate. The clinical documentation submitted for review does not provide any evidence that the patient is on a controlled substance that would require monitoring for compliance. The California Medical Treatment and Utilization Schedule recommends drug testing for patients when there is suspicion of illicit drug use or the need to monitor for compliant behavior to a prescribed medication schedule. As the clinical documentation does not indicate the patient is suspected of illicit drug use and there is no indication of the need to monitor the patient's medication usage through urine drug screens, the urine toxicology would not be indicated. As such, the requested Urine toxicology is not medically necessary or appropriate.

EMG/NCS bilateral upper and lower extremities.: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 177-179; 303-305..

Decision rationale: The Physician Reviewer's decision rationale: The requested EMG/NCS bilateral upper and lower extremities is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine recommends electrodiagnostic studies of the upper and lower extremities when there is subtle evidence of neurological deficits that require further clarification. The clinical documentation submitted for review does not provide any evidence other than a positive compression test of the cervical spine that the patient has any neurological deficits that require clarification. Additionally, the clinical documentation submitted for review does not provide any evidence of neurological deficits of the lower extremities other than a positive straight leg raising test bilaterally. However, the patient's straight leg raising test does not clearly identify if reproduced pain is for the low back or

radiating into the lower extremities and it does not identify at what level pain is reproduced. Therefore, the need for an EMG/NCS of the bilateral upper and lower extremities cannot be determined. As such, the requested EMG/NCS bilateral upper and lower extremities is not medically necessary or appropriate.

FCE: 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).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 77-89.. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness for Duty Chapter, Functional Capacity Evaluation (FCE).

Decision rationale: The Physician Reviewer's decision rationale: The requested FCE is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine recommends the use of Functional Capacity Evaluations to obtain a more precise delineation of a patient's capabilities than what is available from a routine physical examination. However, the Official Disability Guidelines do not recommend Functional Capacity Evaluations unless a patient is at or near maximum medical improvement. The clinical documentation submitted for review does not provide any evidence that the patient is at or near maximum medical improvement with an intention to return to work. Therefore, the need to evaluate the patient's functional capabilities and physical demand analysis would not be indicated. As such, the requested FCE is not medically necessary or appropriate.

Cold therapy unit: 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).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg Chapter, Continuous Flow Cryotherapy.

Decision rationale: The Physician Reviewer's decision rationale: The requested cold therapy unit is not medically necessary or appropriate. The Official Disability Guidelines do not recommend the use of a cold therapy unit in the absence of surgical intervention. The clinical documentation does not provide any evidence that the patient is a surgical candidate or has recently undergone surgical intervention. Additionally, the clinical documentation submitted for review does not provide any evidence that the patient has failed to respond to self-application of hot and cold packs as recommended by the American College of Occupational and Environmental Medicine. Therefore, a cold therapy unit would not be indicated. As such, the requested cold therapy unit is not medically necessary or appropriate.

IF unit.: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS). Page(s): 118..

Decision rationale: The Physician Reviewer's decision rationale: The requested IF unit is not medically necessary or appropriate. The clinical documentation submitted for review does not clearly identify what types of conservative treatments the patient has failed to respond to. The California Medical Treatment and Utilization Schedule recommends interferential units for patients who have failed to respond to all lesser conservative treatments to include a TENS unit. There is no documentation that the patient has failed to respond to any lesser conservative treatments. Additionally, the request as it is written does not clearly identify whether this is for purchase or for rental. The California Medical Treatment and Utilization Schedule recommends the purchase of an interferential unit be based on a 30-day in home trial that provides significant functional benefit and pain relief as an adjunct therapy to active therapy. There is no documentation that the patient has undergone a trial of an interferential unit. As such, the requested IF unit would not be medically necessary or appropriate.