

Case Number:	CM13-0047035		
Date Assigned:	12/27/2013	Date of Injury:	04/28/2012
Decision Date:	06/13/2014	UR Denial Date:	10/07/2013
Priority:	Standard	Application Received:	10/29/2013

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, and is licensed to practice in Illinois. 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/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 injured worker is a 36 year old male with a reported injury dated on 04/28/2012; the mechanism from injury was opening up a door. The clinical note dated 09/25/2013, the injured worker complained of back pain, and left upper extremity pain. Objective findings were noted as paraspinal spasm and tenderness around the left shoulder and elbow; the left elbow with a positive Cozen's. Decreased sensation of left anterolateral shoulder and arm, and left arm strength was 4/5. The injured worker's diagnoses included thoracic musculoligamentous strain/sprain (847.1); lumbosacral musculoligamentous strain/sprain with radiculitis (847.2, 724.4), left elbow sprain (841.9); bilateral elbow lateral epicondylitis (726.32); and left wrist strain/sprain (842.0). The request for authorization was submitted on 10/24/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

INTERFERENTIAL (IF) UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 120.

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

Decision rationale: The requested interferential unit is not medically necessary. The clinical notes submitted for review does support that the injured worker has muscle pain and spasming. California Medical Treatment Utilization Schedule recommends interferential units when all other lesser forms of chronic pain management have failed to provide pain relief for the injured worker. The clinical documentation does not provide any evidence that the injured worker has failed to respond to a TENS unit or other lesser forms of pain management. Additionally, there is no documentation that the injured worker was not tolerant to medications or that medications are contraindicated to the patient. California Medical Treatment Utilization Schedule recommends an interferential as an adjunct therapy to physical activity. The clinical documentation does not provide any evidence that the injured worker is participating in any type of active therapy to include a home exercise program. Additionally, California Medical Treatment Utilization Schedule recommends a 30 day trial that provides functional benefit and evidence of pain relief to support the purchase of this type of durable medical equipment. The request, as it is submitted, does not clearly identify whether this is for rental or purchase. The clinical documentation fails to provide any evidence that the injured worker has ever undergone a clinical trial of an interferential unit. Therefore, the need for this type of therapy would not be supported. As such, the requested interferential unit is not medically necessary.

PHYSICAL THERAPY 2X6: Upheld

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

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

Decision rationale: The request for physical therapy 2 times a week for 6 weeks is not medically necessary. It is noted that the injured worker has complained of the left shoulder and back as a chronic pain. There is no documentation of previous physical therapy, effectiveness, or home exercises performed by the injured worker. There is also a lack of clinical evidence to suggest a new injury or procedure that would cause a new functional deficit and warrant need for physical therapy. According to the CA MTUS guidelines active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. It is noted that the injured worker's left shoulder's strength is a 4/5; however, endurance, functionality, range of motion and flexibility are not addressed. Furthermore, there is a lack of information in regards of the injured worker's lumbar and thoracic spine's strength, endurance, functionality, range of motion and flexibility. Therefore, the request for physical therapy 2 times a week for 6 weeks is not medically necessary.

LUMBAR SPINE BRACE: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Lumbar support.

Decision rationale: The request for lumbar spine brace is not medically necessary. The injured worker was documented with lumbosacral musculoligamentous strain/sprain with radiculitis. American College of Occupational and Environmental Medicine Guidelines state that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. According to the Official Disability Guidelines lumbar support is not recommended for prevention. There is strong and consistent evidence that lumbar supports were not effective in preventing neck and back pain. There is a lack of evidence documented of lower back weakness or instability. Therefore, the request for a lumbar spine brace is not medically necessary.

HOT/COLD UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, 3rd Edition, Low Back Disorders, Chapter (update to Chapter 12), pg. 155.

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, cold/heat packs.

Decision rationale: The request for hot/cold unit is not medically necessary. The injured worker was noted for having chronic back and left upper extremity pain. According to the Official Disability Guidelines cold/heat packs are recommended as an option for acute pain. At-home local applications of cold packs in the first few days of acute complaint; thereafter, applications of heat packs or cold packs. Continuous low-level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. The evidence for the application of cold treatment to low-back pain is more limited than heat therapy, with only three poor quality studies located that support its use, but studies confirm that it may be a low risk low cost option. There is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful for pain reduction and return to normal function. Moreover, there is a lack of evidence to suggest the pain is acute and would benefit from cold/heat packs. The request is of a device and not packs. Furthermore, the request does not include the duration of use. Therefore, the request for hot/cold unit is not medically necessary.

CANE: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG for Knee and Leg regarding Walking Aids.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, walking aids (canes, crutches, braces, orthoses & walkers).

Decision rationale: The request for a cane is not medically necessary. The injured worker had left shoulder impingement syndrome and left elbow sprain/strain. According to the official disability guidelines using a cane in the hand contralateral to the symptomatic knee might shift the body's center of mass towards the affected limb, thereby reducing the medially directed ground reaction force, in a similar way as that achieved with the lateral trunk lean strategy described above. The injured worker is also noted as having bilateral wrist strain/sprain, causing difficulty to load weight to either side of bilateral upper extremities. Furthermore, there is a lack of clinical evidence of functional deficits regarding gait, disease process, or instability of lower extremities for ambulation. Therefore, the request for a cane is not medically necessary.

COMBINATION/COMPOUND: Upheld

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

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

Decision rationale: The request is for combination/compound medication Fluriflex 180gm is not medically necessary. Medication list not provided, there is no clinical evidence of oral analgesics or muscle relaxers, effectiveness, side effects provided. CA MTUS states topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The guidelines continue to state that there is no peer-reviewed literature to support the use of topical Baclofen and other muscle relaxants. Cyclobenzaprine component is a muscle relaxant and ingredient in topical medication Fluriflex. The guidelines go on to say any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Therefore, request for combination/compound Fluriflex 180gm is not medically necessary.

COMPOUND MEDICATION TGHOT 180GM: Upheld

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

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

Decision rationale: The request is for compound medication TGHot 180gm is not medically necessary. The TGHot cream is composed of (Tramadol/Gabapentin/Menthol/Camphor/Capsaicin). According to CA MTUS any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The MTUS guideline do not recommend to topical use of Gabapentin. Therefore, the request for compound medication TGHot 180gm is not medically necessary.

RELAFEN 750MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs). Page(s): 67-68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 68-73.

Decision rationale: The request is for Relafen 750mg # 60 is not medically necessary. It is noted that the injured worker's first visit with prescribing provided as evidence of box #16 per clinical note dated 09/30/2013. According to the CA MTUS guidelines (Relafen) the recommended starting dose is 1000 mg PO. The dose can be divided into 500 mg PO twice a day. Additional relief may be obtained with a dose of 1500 mg to 2000 mg per day. The maximum dose is 2000 mg/day. Patients weighing less than 50 kg may be less likely to require doses greater than 1000 mg/day. There is no clinical evidence of the injured worker's weight in comparison to recommended dose. The guidelines continue to state that the lowest effective dose of Relafen should be sought for each patient. There is a lack of clinical evidence if the injured worker has had Relafen in the past or if this is an initial dose. Therefore, the request for Relafen 750mg # 60 is not medically necessary.

OMEPRAZOLE 20MG #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, (GI) Gastrointestinal symptoms & cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 68.

Decision rationale: The request for Omeprazole 20mg #60 is not medically necessary. There is no documentation that the injured worker had a diagnosis of gastric esophageal reflux, heart burn, or a form of indigestion. The CA MTUS guidelines state a non-selective NSAID with either a PPI (Proton Pump Inhibitor, for example, 20 mg Omeprazole daily) or Misoprostol (200 mg four times daily) or (2) a Cox-2 selective agent. Long-term PPI use (> 1 year) has been shown to increase the risk of hip fracture. However, there is a lack of clinical evidence of the injured worker having been on a NSAIDs causing a need for a proton pump inhibitor. Therefore, the request for Omeprazole 20mg # 60 is not medically necessary.