

Case Number:	CM13-0067031		
Date Assigned:	01/03/2014	Date of Injury:	01/18/2000
Decision Date:	04/07/2014	UR Denial Date:	12/05/2013
Priority:	Standard	Application Received:	12/17/2013

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 Internal Medicine, 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 56 year old male who was injured on 01/18/2000 when he sustained an injury to back, left shoulder, neck, knee, head, and elbows, unknown mechanism of injury. Treatment history included Ultracet, omeprazole 20 mg, Naproxen 550 mg, Synvisc injection to right knee, unloader brace, lumbar cushion, Toradol injection, vitamin B12 injection, gabapentin 600 mg, chiropractic treatment, Darvocet, Vicodin, Advil, Tylenol #3, glucosamine Chondroitin, ankle brace, acupuncture, Norco 4/325 mg, Cativisc 500/220/150 mg, right shoulder subacromial injection, cane, physical therapy, wrist braces, elbow brace and Voltaren. Diagnoses were as follows: right shoulder impingement, left shoulder pain, internal derangement of left knee, knee pain, status post arthroscopy, left knee medial meniscal tear, L5-S1 facet hypertrophy, bilateral lateral epicondylitis, bilateral cubital syndrome, C4-5, C5-6, C6-7 degenerative disc disease, and anxiety and depression.

IMR ISSUES, DECISIONS AND RATIONALES

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

TGIce (Tramadol 85/Gabapentin 10%/ Menthol 2%/Camphor 2%) 180gm #1QTY: 1.00:
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: Chronic Pain Medical Treatment Guidelines state that gabapentin is not recommended since there is no peer-reviewed literature to support use as a topical product. Further guidelines indicate that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Thus, the request for TG Ice (Tramadol 85/Gabapentin 10%/ Menthol 2%/Camphor 2%) 180gm #1QTY is non-certified.

Fluriflex (Flurbiprofen 15%/Cyclobenzaprine 10%) 180gm #1QTY: 1.00: 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: Chronic Pain Medical Treatment Guidelines state that topical analgesics are largely experimental and there is little evidence to support the use of topical NSAIDs (flurbiprofen) for treatment of osteoarthritis of the spine, hip or shoulder and there is no evidence to support the use for neuropathic pain. Additionally, baclofen and other muscle relaxants are not recommended since there is no evidence for its use as a topical product. Further guidelines indicate any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Thus the request for Fluriflex (Flurbiprofen 15%/Cyclobenzaprine 10%) 180gm #1QTY: 1.00 is not medically necessary and non-certified.

Electromyography (EMG) Right Lower Extremity QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

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), Low Back - Lumbar & Thoracic (Acute & Chronic), EMGs (Electromyography)

Decision rationale: CA MTUS Guidelines state that EMGs are recommended to identify specific nerve compromise on the neurologic examination. ODG Guidelines state that EMGs may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. In this case, this patient has chronic lower back and bilateral feet pain; however, on physical exam, there is no documentation of objective neurological deficits such as decreased reflexes, diminished sensation or weakness in bilateral lower extremities. Due to lack of documentation of such findings, the medical necessity has not been established, and hence the request is non-certified.

Electromyography (EMG) Left Lower Extremity QTY: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

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), Low Back - Lumbar & Thoracic (Acute & Chronic), EMGs (Electromyography)

Decision rationale: CA MTUS Guidelines state that EMGs are recommended to identify specific nerve compromise on the neurologic examination. ODG Guidelines state that EMGs may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. In this case, this patient has chronic lower back and bilateral feet pain; however, on physical exam, there is no documentation of objective neurological deficits such as decreased reflexes, diminished sensation or weakness in bilateral lower extremities. Due to lack of documentation of such findings, the medical necessity has not been established, and hence the request is non-certified.

Nerve Conduction Study (NCS) Right Lower Extremity QTY: 1.00: 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) , 11TH Edition, 2013, Low Back, Nerve Conduction Studies (NCS)

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), Low Back - Lumbar & Thoracic (Acute & Chronic), Nerve Conduction Studies (NCS)

Decision rationale: CA MTUS Guidelines, states that Nerve Conduction Studies, (NCSs), are recommended to identify specific nerve compromise on the neurologic examination. As per ODG, there is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. In this case, this patient has chronic lower back and bilateral feet pain; however, on physical exam, there is no documentation of objective neurological deficits such as decreased reflexes, diminished sensation or weakness in bilateral lower extremities. Due to lack of documentation of such findings, the medical necessity has not been established, and hence the request is non-certified.

Nerve Conduction Study (NCS) Left Lower Extremity QTY: 1.00: 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) , 11TH Edition, 2013, Low Back, Nerve Conduction Studies (NCS)

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), Low Back - Lumbar & Thoracic (Acute & Chronic), Nerve Conduction Studies (NCS)

Decision rationale: CA MTUS Guidelines, states that Nerve Conduction Studies, (NCSs), are recommended to identify specific nerve compromise on the neurologic examination. As per ODG, there is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. In this case, this patient has chronic lower back and bilateral feet pain; however, on physical exam, there is no documentation of objective neurological deficits such as decreased reflexes, diminished sensation or weakness in bilateral lower extremities. Due to lack of documentation of such findings, the medical necessity has not been established, and hence the request is non-certified.

Extracorporeal Shockwave Therapy Low Back QTY: 1.00: 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), 11th Edition, Low Back, 2013, Extracorporeal Shockwave Therapy

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 - Lumbar & Thoracic (Acute and Chronic), Shock wave Therapy

Decision rationale: ODG Guidelines state that extracorporeal shockwave therapy is not recommended. The available evidence does not support the effectiveness of ultrasound or shock wave for treating Low Back Pain. In the absence of such evidence, the clinical use of these forms of treatment is not justified, thus, the request is non-certified.

Extracorporeal Shockwave Therapy Left Shoulder QTY: 1.00: 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), 11th Edition, Low Back, 2013, Extracorporeal Shockwave Therapy

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

Decision rationale: CA MTUS and ODG, extracorporeal shock wave therapy is recommended for calcifying tendinitis but not for other shoulder disorders. Records review indicates that no such diagnosis has been established and thus the request is non-certified.