

Case Number:	CM13-0067384		
Date Assigned:	01/03/2014	Date of Injury:	01/16/2012
Decision Date:	05/19/2014	UR Denial Date:	12/10/2013
Priority:	Standard	Application Received:	12/17/2013

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 & 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 64-year-old male who reported an injury on 01/16/2012. The mechanism of injury occurred when the injured worker was pulling and lifting a patient, while working as a registered nurse. The injured worker immediately experienced excruciating pain throughout the entire back. The injured worker initially received x-rays of the back and a morphine injection, and was prescribed anti-inflammatory medications. A few days after the initial injury, the injured worker developed significant swelling in the bilateral lower extremities, feet, and groin area. Due to this development, the injured worker was recommended for immediate surgery and received a left GSV plus STAV phlebectomy procedure to the left leg, on 01/26/2012. After the surgery, the injured worker continued to receive conservative treatment and was referred for a course of physical therapy. It was noted that the injured worker developed significant and severe urgent incontinence that he attributes to the initial injury. The injured worker was then referred to an orthopedic surgeon who obtained x-rays of the lumbar spine and diagnosed the injured worker with L4-5 listhesis, and recommended immediate surgery; however, it is unclear if this was ever performed. In 01/2013, it was noted that the injured worker had been participating in aquatic therapy with reported benefit. In 02/2013, the injured worker was again referred for a posterior interbody fusion at L4-5 secondary to the listhesis previously identified. As a result of the injury, the injured worker has developed depression and anxiety and is treated by a psychiatrist.

IMR ISSUES, DECISIONS AND RATIONALES

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

PURCHASE OF ONE KRONOS PNEUMATIC LUMBAR SPINE BRACE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

Decision rationale: California MTUS/ACOEM Guidelines only recommend lumbar supports in the acute phase of treatment; however, California Guidelines do not specifically address the need for lumbar support as it relates to spinal instability. Therefore, Official Disability Guidelines were supplemented. Official Disability Guidelines recommend lumbar supports, or bracing, as an option for compression fractures and specific treatment of spondylolisthesis. Although the injured worker does have documented spondylolisthesis, there was no evidence that a pneumatic brace was required in place of an off-the-shelf traditional corset. Although the appeal letter dated 12/13/2013 indicated that a pneumatic device is specifically designed to provide compression, warmth, and maintain proper spinal alignment, guidelines recommend immobilization with a traditional corset brace. Regular abdominal belts and lumbar support orthoses are sufficient in providing spinal stability; therefore, the need for a pneumatic brace has not been supported. As such, the request for purchase of 1 Kronos pneumatic lumbar spine brace is not medically necessary.

BENADRYL 25MG #60: Overturned

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 Thormann, M., Amthaer, H., Adolf, D., Wollrab, A., Ricke, J., & Speck, O. (2013). Efficacy of Diphenhydramine in the Prevention of Vertigo and Nausea at 7t MRI. *European Journal of Radiology*, 82(5), 768-772. Khilnani, A. K., Thaddanee, R., & Khilnani, G. (2013). An

Decision rationale: California MTUS/ACOEM Guidelines and Official Disability Guidelines do not specifically address the need for Benadryl in treating vertigo; therefore, current medical literature was supplemented. In review of the medical records submitted, it was noted that the injured worker is being prescribed Benadryl to treat his symptoms of vertigo. Current medical literature contains several studies detailing the efficacy of diphenhydramine (Benadryl) in the treatment of vertigo and nausea related to vertigo. As current medical literature supports the use of this medication in treating dizziness and nausea, continued use of this medication is appropriate. As such, the request for Benadryl 25 mg #60 is medically necessary.

FLURIFLEX CREAM 120GM: 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: California MTUS/ACOEM Guidelines recommend topical analgesics to treat primarily neuropathic and osteoarthritic pain. Guidelines state that the only FDA-approved NSAID for topical use is diclofenac 1%. The current request contains a topical formulation of Flurbiprofen, an NSAID, which is not recommended by guidelines. Additionally, guidelines state topical NSAIDs such as diclofenac, do not have any support detailing their efficacy in treatment of the spine, hip, or shoulder. With this information, continued use of this topical cream is not indicated. As such, the request for FluriFlex cream 120 grams is not medically necessary.

TG ICE 120GM: 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: California MTUS/ACOEM Guidelines recommend topical analgesics to treat primarily neuropathic and osteoarthritic pain. California MTUS/ACOEM Guidelines also state a compounded product containing at least one drug (or drug class) that is not recommended, deems the entire product not recommended. TG Ice cream contains a formulation of topical gabapentin, capsaicin, and tramadol. Guidelines do not support the use of topical gabapentin, as there is no peer-reviewed literature to support its use. Additionally, capsaicin is only recommended in a 0.025% formulation and the TG Ice contains a 0.05% formulation. Additionally, topical tramadol is not recommended for use in any condition except postherpetic neuralgia or open skin lesions. As this medication contains formulations of other drugs not recommended for use, the entire compound is not recommended. As such, the request for TG Ice 120 grams is not medically necessary.