MAXIMUS Federal Services

Case Number:	CM14-0015984		
Date Assigned:	07/02/2014	Date of Injury:	08/07/2012
Decision Date:	09/05/2014	UR Denial Date:	01/21/2014
Priority:	Standard	Application Received:	02/07/2014

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 46-year-old female who reported an injury on 08/07/2012 due to cumulative trauma while performing normal job duties. The injured worker reportedly sustained an injury to her hand, low back and right shoulder. The injured worker underwent right hand surgery for removal of a granuloma. The injured worker's treatment history included multiple medications, physical therapy, acupuncture and LINT as well as chiropractic care. The injured worker was evaluated on 11/15/2013. It was documented that the injured worker had continued shoulder and low back complaints. Physical findings included limited range of motion secondary to pain of the lumbar spine and limited range of motion of the right shoulder secondary to pain with tenderness and weakness upon palpation of the acromioclavicular joint with a positive impingement and supraspinatus test of the right shoulder. The injured worker's diagnoses included lumbar disc with radiculopathy, lumbar radiculopathy, lumbar sprain/strain and shoulder internal derangement as well as rotator cuff syndrome of the right shoulder and right shoulder sprain/strain. The injured worker's treatment plan included continued medications, physical therapy and acupuncture.

IMR ISSUES, DECISIONS AND RATIONALES

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

KETOPROFEN/CYCLOBENZAPRINE/LIDOCAIN 10%/3%/15% 120GMS: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The requested ketoprofen/cyclobenzaprine/lidocaine 120 gm is not medically necessary or appropriate. The clinical documentation does support that the injured worker has ongoing pain complaints that would benefit from medication. However, the California Medical Treatment Utilization Schedule does not support the use of ketoprofen or lidocaine as it is not FDA-approved in a topical formulation to treat neuropathic pain. Additionally, the California Medical Treatment Utilization Schedule does not support the use of cyclobenzaprine or other muscle relaxants in a topical formulation, as there is little scientific data to support the efficacy and safety of this medication. Furthermore, the request as it is submitted does not specifically identify a body part for treatment. In the absence of this information, the appropriateness of the request cannot be determined. As such, the requested ketoprofen/cyclobenzaprine/lidocaine 10%/3%/15% at 120 gm is not medically necessary.

FLURBIPROFEN/CAPSAICIN/MENTHOL/CAMPHOR 10%/0.25%/2%/1% COMPOUND CREAM: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The requested flurbiprofen/capsaicin/menthol/camphor compounded cream is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the injured worker has ongoing pain complaints that would benefit from medication management. However, the California Medical Treatment Utilization Schedule recommends capsaicin as a topical analgesic when the injured worker has failed to respond to all other first-line medications. The clinical documentation submitted for review does not provide any evidence that the injured worker has failed to respond to first-line medications, such as oral anticonvulsants or antidepressants. Additionally, the request as it is submitted does not specifically identify a body part. The injured worker has two pain generators the low back and the shoulder. The California Medical Treatment Utilization Schedule does not support the use of nonsteroidal anti-inflammatory drugs for the management of spine pain. The California Medical Treatment Utilization Schedule does not recommend the use of any medication that contains at least one drug, or drug class, that is not supported by the guideline recommendations. As such, the requested flurbiprofen/capsaicin/menthol/ camphor 10%/0.25%/2%/1% compounded cream is not medically necessary.

ACUPUNCTURE TWO (2) TIMES A WEEK FOR SIX (6) WEEKS: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The requested acupuncture 2 times a week for 6 weeks is not medically necessary or appropriated. The clinical documentation submitted for review does indicate that the injured worker has been participating in acupuncture since at least 02/2013. The clinical documentation fails to provide any significant functional benefit or reduction of medications to support the continued use of this treatment modality. The California Medical Treatment Utilization Schedule recommends documented functional benefit and pain relief to support the continued use of acupuncture. As such, the requested acupuncture 2 times a week for 6 weeks is not medically necessary.

PHYSICAL THERAPY TWO (2) TIMES A WEEK FOR SIX (6) WEEKS: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The requested physical therapy 2 times a week for 6 weeks is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends that injured workers be transitioned into a home exercise program to maintain improvement levels obtained during skilled physical therapy. The clinical documentation does indicate that the injured worker has been participating in physical therapy since at least 02/2013. There are no factors to preclude further progress of the injured worker while participating in a home exercise program. As such, the requested physical therapy 2 times a week for 6 weeks is not medically necessary.

ORTHOPEDIC REFERRAL: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92.

Decision rationale: The requested orthopedic referral is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine recommends specialty consultations for injured workers at risk for delayed recovery when the treating provider has exhausted all diagnostic and conservative treatments within his scope of practice. The clinical documentation does not provide any evidence that the treating provider has exhausted all resources within his scope of practice and requires additional expertise to assist with the treatment planning. As such, the requested orthopedic referral is not medically necessary.

SPINE SURGEON REFERRAL: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 82-89.

Decision rationale: The requested spine surgeon referral is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine recommends specialty consultations for injured workers at risk for delayed recovery when the treating provider has exhausted all diagnostic and conservative treatments within his scope of practice. The clinical documentation does not provide any evidence that the treating provider has exhausted all resources within his scope of practice and requires additional expertise to assist with the treatment planning. As such, the requested spine surgeon referral is not medically necessary.