

Case Number:	CM14-0126325		
Date Assigned:	08/13/2014	Date of Injury:	03/25/2003
Decision Date:	09/22/2014	UR Denial Date:	07/28/2014
Priority:	Standard	Application Received:	08/08/2014

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 Anesthesiology, has a subspecialty in Pain Management 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 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:

According to the records made available for review, this is a 56-year-old female with a 3/25/03 date of injury. At the time (6/19/14) of request for authorization for Flurbiprofen 20% TGIce (Tramadol 8%, Gabapentin 10%, Menthol 2%, Camphor 2%), urine analysis, Home Health Care 12 hours daily, 7 days weekly with RN evaluation every 12 weeks, EMG lower extremities, NCS lower extremities, and orthopedic mattress, there is documentation of subjective (bilateral shoulder pain with numbness into the fingers, right elbow pain with numbness in the arm, bilateral wrist pain with numbness and tingling into the fingers, neck pain with numbness and tingling into the hands and fingers, low back pain radiating to the legs with numbness and tingling, right hip pain, bilateral knee pain, and right ankle pain) and objective (antalgic gait, tenderness to palpation over both shoulders with impingement signs of the right shoulder and decreased right shoulder range of motion; tenderness to palpation over the right lateral epicondyle; positive Finkelstein's and Tinel's tests bilaterally and decreased right wrist range of motion; diminished brachioradialis reflex on the right, cervical paraspinal tenderness with spasms, positive foraminal compression test, decreased cervical range of motion; positive straight leg raise test, decreased ankle and knee reflexes on the right, tenderness over the lumbar paraspinal musculature with spasms and decreased range of motion; right hip tenderness with decreased range of motion, tenderness over bilateral knees with positive McMurray's test, and tenderness over the right ankle with decreased range of motion) findings, current diagnoses (cervical spine multi-level disc bulges, lumbar spine multi-level disc bulges, right elbow lateral epicondylitis, right cubital tunnel syndrome, right shoulder sprain/strain, bilateral De Quervain's syndrome, bilateral carpal tunnel syndrome, osteoarthritis of the right hip, sprain of left knee, right knee meniscal derangement, right ankle sprain, shoulder impingement syndrome, and depression/stress/anxiety), and treatment to date (acupuncture, analgesic creams, ongoing

therapy with Vicodin, Soma and Ibuprofen; wrist brace, lumbar support, and TENS unit). In addition, medical report identifies previous EMG/NCV of the bilateral extremities was performed in 2005. Regarding urine analysis, there is no documentation of abuse, addiction, or poor pain control in the patient. Regarding Home Health Care 12 hours daily, 7 days weekly with RN evaluation every 12 weeks, there is no documentation that the patient requires recommended medical treatment (where homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom is not the only care needed) and the patient is homebound on a part-time or intermittent basis. In addition, the requested frequency and number of hours per week exceeds guidelines. Regarding EMG lower extremities and NCS lower extremities, there is no documentation of objective evidence of radiculopathy and an interval injury or progressive neurologic findings.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flurbiprofen 20% TGIce (Tramadol 8%, Gabapentin 10%, Menthol 2%, Camphor 2%): Upheld

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

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

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that many agents are compounded as monotherapy or in combination for pain control; that ketoprofen, lidocaine (in creams, lotion or gels), capsaicin in a 0.0375% formulation, baclofen and other muscle relaxants, and gabapentin and other antiepilepsy drugs are not recommended for topical applications; and that any compounded product that contains at least one drug (or drug class) that is not recommended, is not recommended. Within the medical information available for review, there is documentation of diagnoses of cervical spine multi-level disc bulges, lumbar spine multi-level disc bulges, right elbow lateral epicondylitis, right cubital tunnel syndrome, right shoulder sprain/strain, bilateral De Quervain's syndrome, bilateral carpal tunnel syndrome, osteoarthritis of the right hip, sprain of left knee, right knee meniscal derangement, right ankle sprain, shoulder impingement syndrome, and depression/stress/anxiety. However, the requested compounded medication contains at least one drug (Gabapentin) that is not recommended. Therefore, based on guidelines and a review of the evidence, the request for Flurbiprofen 20% TGIce (Tramadol 8%, Gabapentin 10%, Menthol 2%, Camphor 2%) is not medically necessary.

Urine Analysis: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines:Pain: Urine Drug Testing, Urinalysis.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines On-Going Management Page(s): 78.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of abuse, addiction, or poor pain control in patient under on-going opioid treatment, as criteria necessary to support the medical necessity of Urine Drug Screen. Within the medical information available for review, there is documentation of diagnoses of cervical spine multi-level disc bulges, lumbar spine multi-level disc bulges, right elbow lateral epicondylitis, right cubital tunnel syndrome, right shoulder sprain/strain, bilateral De Quervain's syndrome, bilateral carpal tunnel syndrome, osteoarthritis of the right hip, sprain of left knee, right knee meniscal derangement, right ankle sprain, shoulder impingement syndrome, and depression/stress/anxiety. In addition, there is documentation of on-going opioid treatment. However, there is no documentation of abuse, addiction, or poor pain control in the patient. Therefore, based on guidelines and a review of the evidence, the request for urine analysis is not medically necessary.

Home Health Care 12 hours daily, 7 days weekly with RN evaluation every 12 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 Home health services Page(s): 51.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation that the patient requires recommended medical treatment (where homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom is not the only care needed) and the patient is homebound on a part-time or intermittent basis, as criteria necessary to support the medical necessity of home health services. In addition, MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of no more than 35 hours per week. Within the medical information available for review, there is documentation of diagnoses of cervical spine multi-level disc bulges, lumbar spine multi-level disc bulges, right elbow lateral epicondylitis, right cubital tunnel syndrome, right shoulder sprain/strain, bilateral De Quervain's syndrome, bilateral carpal tunnel syndrome, osteoarthritis of the right hip, sprain of left knee, right knee meniscal derangement, right ankle sprain, shoulder impingement syndrome, and depression/stress/anxiety. However, there is no documentation that the patient requires recommended medical treatment (where homemaker services like shopping, cleaning, and laundry, and personal care given by home health aides like bathing, dressing, and using the bathroom is not the only care needed) and the patient is homebound on a part-time or intermittent basis. In addition, the requested frequency and number of hours per week exceeds guidelines. Therefore, based on guidelines and a review of the evidence, the request for Home Health Care 12 hours daily, 7 days weekly with RN evaluation every 12 weeks is not medically necessary.

EMG lower extremities: 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. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Electrodiagnostic studies Other Medical Treatment Guideline or Medical Evidence: Nerve Conduction Velocity Studies (http://www.aetna.com/cpb/medical/data/500_599/0502.html).

Decision rationale: MTUS reference to ACOEM guidelines identifies documentation of focal neurologic dysfunction in patients with low back symptoms lasting more than three to four weeks, as criteria necessary to support the medical necessity of electrodiagnostic studies. ODG identifies documentation of evidence of radiculopathy after 1-month of conservative therapy, as criteria necessary to support the medical necessity of electrodiagnostic studies. Medical Treatment Guideline necessitates documentation of an interval injury or progressive neurologic findings to support the medical necessity of a repeat study. Within the medical information available for review, there is documentation of diagnoses of cervical spine multi-level disc bulges, lumbar spine multi-level disc bulges, right elbow lateral epicondylitis, right cubital tunnel syndrome, right shoulder sprain/strain, bilateral De Quervain's syndrome, bilateral carpal tunnel syndrome, osteoarthritis of the right hip, sprain of left knee, right knee meniscal derangement, right ankle sprain, shoulder impingement syndrome, and depression/stress/anxiety. In addition, there is documentation of a previous EMG/NCV of the bilateral extremities performed in 2005. Furthermore, there is documentation of subjective evidence of radiculopathy after 1-month of conservative therapy. However, given documentation of objective findings (tenderness over the lumbar paraspinal musculature with spasms and decreased range of motion), there is no documentation of objective evidence of radiculopathy and an interval injury or progressive neurologic findings. Therefore, based on guidelines and a review of the evidence, the request for EMG lower extremities is not medically necessary.

NCS lower extremities: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Nerve Conduction Velocity Studies (http://www.aetna.com/cpb/medical/data/500_599/0502.html).

Decision rationale: MTUS reference to ACOEM guidelines identifies documentation of focal neurologic dysfunction in patients with low back symptoms lasting more than three to four weeks, as criteria necessary to support the medical necessity of electrodiagnostic studies. ODG identifies documentation of evidence of radiculopathy after 1-month of conservative therapy, as criteria necessary to support the medical necessity of electrodiagnostic studies. In addition, ODG does not consistently support performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. Medical Treatment Guideline necessitates

documentation of an interval injury or progressive neurologic findings to support the medical necessity of a repeat study. Within the medical information available for review, there is documentation of diagnoses of cervical spine multi-level disc bulges, lumbar spine multi-level disc bulges, right elbow lateral epicondylitis, right cubital tunnel syndrome, right shoulder sprain/strain, bilateral De Quervain's syndrome, bilateral carpal tunnel syndrome, osteoarthritis of the right hip, sprain of left knee, right knee meniscal derangement, right ankle sprain, shoulder impingement syndrome, and depression/stress/anxiety. In addition, there is documentation of a previous EMG/NCV of the bilateral extremities performed in 2005. Furthermore, there is documentation of subjective evidence of radiculopathy after 1-month of conservative therapy. However, given documentation of objective findings (tenderness over the lumbar paraspinal musculature with spasms and decreased range of motion), there is no documentation of objective evidence of radiculopathy and an interval injury or progressive neurologic findings. Therefore, based on guidelines and a review of the evidence, the request for NCS lower extremities is not medically necessary.

Orthopedic Mattress: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Back Treatment section:Mattress Selection.

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, Mattress selection.

Decision rationale: MTUS does not address this issue. ODG identifies that there are no high quality studies to support purchase of any type of specialized mattress or bedding as a treatment for low back pain. Therefore, based on guidelines and a review of the evidence, the request for orthopedic mattress is not medically necessary.