

Case Number:	CM14-0026621		
Date Assigned:	06/13/2014	Date of Injury:	01/15/2013
Decision Date:	07/18/2014	UR Denial Date:	02/12/2014
Priority:	Standard	Application Received:	03/03/2014

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 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 59-year-old female who reported an injury on 01/15/2013. The mechanism of injury was noted to be the injured worker slid down a staircase on her stomach. The injured worker's prior treatments included medications, physical and manipulative therapy, injections, and shockwave therapy. Her diagnoses were noted to be lumbago; displacement of lumbar intervertebral discs; lumbar spinal stenosis; annular tear at the L5-S1 disc; lumbar facet hypertrophy syndrome; neural foraminal stenosis at L3-4, L4-5, and L5-S1; and myalgia. The injured worker was seen for an evaluation on 01/06/2014. Her subjective complaints were pain in the low back that radiated to L3 and L4 dermatomes, radiating pain in the right knee, pain in the mid and upper back, and left knee. She indicated her pain in the mid and upper back a 5/10, she indicated her pain in the lower back a 7/10, pain in the right knee a 2/10, and pain in the left knee a 2/10. The objective findings included tenderness to palpation over the paraspinal muscles of the cervical spine, thoracic spine, and lumbar spine. Range of motion to the lumbar spine was restricted. Straight leg raise test was positive bilaterally. Trigger points were noted in the lumbar spine. She had tenderness to palpation of the left wrist and hand and tenderness to palpation of the bilateral knees, right ankle, and right foot. The injured worker stated that the last lumbar epidural steroid injection dated 12/19/2013 did not provide her any symptom relief. The treatment plan is for physical therapy to be put on hold at this time, she was prescribed Fluriflex and TGHOT in addition to omeprazole and Motrin. She was referred for extracorporeal shockwave therapy of the lumbar spine, and referred to a spine surgeon for a consultation regarding the lumbar spine. The provider's rationale for the requested shockwave therapy was not provided within the documentation; however, the provider's rationale for the topical medications, Fluriflex and TGHOT, was provided within the documentation. The request for authorization form for medical treatment was not provided within the documentation.

IMR ISSUES, DECISIONS AND RATIONALES

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

ONE (1) EXTRACORPOREAL SHOCKWAVE THERAPY (ECSWT) FOR THE LUMBAR SPINE: 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).

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, Shock wave therapy.

Decision rationale: The request for 1 extracorporeal shockwave therapy for the lumbar spine is non-certified. The Official Disability Guidelines do not recommend shockwave therapy. The available evidence does not support the effectiveness of ultrasound or shockwave for treating low back pain. In the absence of such evidence, the clinical use of these forms of treatment are not justified and should be discouraged. The injured worker has participated in shockwave therapy according to the documentation although the number of visits is unspecified and the efficacy was not provided. According to the most recent clinical evaluation the injured worker still continues to have lumbar symptoms of pain. Shockwave therapy has not been effective for the injured worker based upon the clinical evaluation and it is not recommended by the Guidelines. Therefore, the request for 1 extracorporeal shockwave therapy for the lumbar spine is not medically necessary.

ONE (1) PRESCRIPTION FOR FLURIFLEX 180GM: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, TOPICAL ANALGESICS.

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

Decision rationale: The request for 1 prescription of Fluriflex 180 grams is non-certified. The California MTUS Chronic Pain Medical Treatment Guidelines state topical analgesics are recommended as an option. However, topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The Guidelines continue that any compounded product that contains at least 1 drug or drug class that is not recommended is not recommended. Medication Fluriflex contains flurbiprofen and cyclobenzaprine. Cyclobenzaprine is not recommended under the Guidelines. The clinical evaluation does not indicate that the injured worker failed any trials of antidepressants or anticonvulsants. The request fails to indicate a dosage frequency. Therefore, the request for 1 prescription of Fluriflex 180 grams is not medically necessary.

ONE (1) PRESCRIPTION FOR TGHOT 180GM: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, TOPICAL ANALGESICS.

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

Decision rationale: The request for 1 prescription for TGHot 180 grams is non-certified. The California MTUS Chronic Pain Medical Treatment Guidelines state topical analgesics are recommended as an option. They are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug or drug class that is not recommended is not recommended. The medication TGHot contains tramadol, gabapentin, and capsaicin. The Guidelines state that gabapentin is not recommended. There is no peer-reviewed literature to support its use. The request fails to indicate a frequency. As such, the request for 1 prescription for TGHot is not medically necessary.