

Case Number:	CM14-0026763		
Date Assigned:	06/13/2014	Date of Injury:	03/12/2004
Decision Date:	07/18/2014	UR Denial Date:	02/06/2014
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 55-year-old female who reported an injury on 03/12/2004. The mechanism of injury was not provided. The clinical note dated 02/18/2014 noted the injured worker presented with complaints of neck pain, bilateral wrist pain, mid back pain, low back pain, and radiation of symptoms in the cervical and thoracic spine into the upper extremities with needle type sensation into the hands. Upon palpation of the cervical spine, there was tenderness over the paracervical muscles bilaterally. The range of motion values for the cervical spine were 40 degrees of flexion, 50 degrees of extension, 70 degrees of right rotation, 70 degrees of left rotation, 40 degrees of right lateral flexion, and 40 degrees of left lateral flexion. There was a positive foraminal compression test bilaterally, and a positive shoulder depression test bilaterally. Palpation over the thoracic spine elicited tenderness over the paralumbar muscles bilaterally. There was a positive Phalen's test bilaterally, and a positive Tinel's sign bilaterally. Prior treatment included medications and physical therapy. The diagnoses were cervical disc disease, lumbar disc disease, thoracic disc disease, bilateral wrist carpal tunnel syndrome, right knee internal derangement, left knee internal derangement, hyperlipidemia, hepatitis B, hypertension, type 2 diabetes mellitus, anxiety, and insomnia. The provider recommended physical therapy 2 times a week for 3 weeks for the cervical spine, thoracic spine, and bilateral wrists, MRI of the cervical spine, transdermal cream, and Flurflex, the provider's rationale was not included and was not provided. The request for authorization form was not included in the medical documents for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY 2X PER WEEK FOR 3 WEEKS FOR CERVICAL SPINE, THORACIC SPINE, AND BILATERAL WRISTS: Upheld

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

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

Decision rationale: The California MTUS Guidelines state that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, and function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific task or exercise. The guidelines allow for up to 10 visits of physical therapy over 4 weeks. The number of physical therapy visits that have already been completed were not documented. The efficacy of the physical therapy treatment was not provided. The injured worker was documented to have been participating in a home exercise program, the provider's rationale for additional physical therapy visits was not provided. As such, the request is not medically necessary.

MRI (MAGNETIC RESONANCE IMAGE) OF THE CERVICAL SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

Decision rationale: The California MTUS/ACOEM Guidelines state in injured workers presenting with true neck or upper back problems, special studies are not needed unless a 3 or 4 week period of conservative care and observation fails to improve symptoms. Most injured workers improve quickly, provided any red flag conditions are ruled out. Criteria for ordering imaging studies include emergence of red flag, physiologic evidence of a tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to an invasive procedure. The included medical documentation lacked evidence of a physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery, clarification of the anatomy prior to an invasive procedure, and the emergence of a red flag. There was a lack of evidence that the injured worker failed a 4 week period of conservative care to include physical therapy and medication. As such, the request is not medically necessary.

TG HOT (TRAMADOL 8%/GABAPENTIN 10%/MENTHOL 2%/CAMPHOR 2%/CAPSAICIN 0.05%) 180 GRAMS APPLY TO AREA OF COMPLAIN: 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.

Decision rationale: The California MTUS Guidelines state that transdermal compounds 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. Any compounded product that contains at least 1 drug that is not recommended, is not recommended. The guidelines note gabapentin is not recommended for topical application. Topical NSAIDs are recommended for osteoarthritis and tendonitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment. They are recommended for short-term use, 4 to 12 weeks. There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. The guidelines do not recommend the use of muscle relaxants or gabapentin for topical application, the medication would not be indicated. The guidelines note that capsaicin is recommended for use if the injured worker is intolerant to or have not responded to other treatments. There is a lack of evidence that the injured worker is intolerant to or unresponsive to other medications to warrant the need for capsaicin. The provider's request does not indicate the frequency, dose, or site at which the cream was intended for. As such, the request is not medically necessary.

**FLURFLEX (FLURBIPROFEN 10%/ CYCLOBENZAPRINE 10%) 180 GRAMS -
APPLY TO AREAS OF COMPLAINT:** 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.

Decision rationale: The California MTUS Guidelines state transdermal compounds 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. Any compounded product that contains at least 1 drug that is not recommended is not recommended. The guidelines note muscle relaxants are not recommended for topical application. The guidelines note cyclobenzaprine is not recommended for topical application. As the guidelines do not recommend the use of muscle relaxants or cyclobenzaprine for topical application, the medication would not be indicated. The provider's request does not indicate the dose or frequency of the cream or the site it was intended for. As such, the request is not medically necessary.