

Case Number:	CM14-0029299		
Date Assigned:	08/01/2014	Date of Injury:	01/01/2011
Decision Date:	12/12/2014	UR Denial Date:	02/20/2014
Priority:	Standard	Application Received:	03/07/2014

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 and Rehabilitation, has a subspecialty in Interventional Spine 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:

The patient is a 23-year-old male with date of injury of 01/01/2011 -01/01/2014. The listed diagnoses per [REDACTED] from 01/29/2014 are: 1. Cervical spine musculoligamentous sprain/strain, rule out cervical spine discogenic disease. 2. Thoracic spine musculoligamentous/strain. 3. Lumbosacral spine musculoligamentous sprain/strain with radiculitis, rule out lumbosacral spine discogenic disease. 4. Bilateral shoulder sprain/strain. 5. Bilateral shoulder impingement syndrome. 6. Bilateral elbow sprain/strain. 7. Bilateral wrist sprain/strain, rule out bilateral wrist carpal tunnel syndrome. 8. Depression. 9. Sleep disturbance secondary to pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fluriflex 180 grams #2 TG-Hot 180 grams: 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 patient presents with neck, back, and bilateral upper extremity pain. The treater is requesting FLURIFLEX 180 G #2, TGHOT 180 G. The MTUS Guidelines page 111 on topical analgesics states that it is largely experimental and used with few randomized control trials to determine efficacy or safety. It is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. MTUS also states, "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." FluriFlex cream is a combination of flurbiprofen 15% and cyclobenzaprine 10%. TGHOT cream is a combination of tramadol/gabapentin/menthol/camphor/capsaicin. The records show that the patient was prescribed FluriFlex and TGHOT cream on 01/29/2014. The request is for 2 separate compound creams. For FluriFlex, cyclobenzaprine is not recommended as a topical compound. For TGHOT, both tramadol and gabapentin compounds are not recommended in topical formulations. Recommendation is for denial.

Hot and Cold Unit: Upheld

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

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 Chapter on Cold/Heat Packs

Decision rationale: This patient presents with neck, back, and bilateral upper extremity pain. The treater is requesting a HOT AND COLD UNIT. The MTUS and ACOEM Guidelines are silent with regards to this request; however, ODG Guidelines recommend at-home local applications of cold pack in the first few days of acute complaints; thereafter, application of heat packs. ODG further states that mechanical circulating units with pumps have not been proven to be more effective than passive hot/cold therapy. The treater does not specify why a hot and cold unit is to be used. The ODG Guidelines do not support the use of mechanical circulating units for the treatment of generalized lumbar pain. At home applications of hot/cold patch should be sufficient. Recommendation is for denial.

Tramadol 50mg #60: 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 initiating opioids Page(s): 76-78.

Decision rationale: This patient presents with neck, back, and bilateral upper extremity pain. The treater is requesting TRAMADOL 50 MG #60. The MTUS Guidelines page 76 to 78 under criteria for initiating opioids recommend that reasonable alternatives have been tried, considering the patient's likelihood of improvement, likelihood of abuse, etc. MTUS goes on to state that baseline pain and functional assessment should be provided. Once the criteria have been met, new course of opioids may be tried.

IF Unit: 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 IF units Page(s): 111-120.

Decision rationale: This patient presents with neck, back, and bilateral upper extremity pain. The treater is requesting IF UNIT. The MTUS Guidelines page 111 to 120 states that interferential current stimulation is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments including return to work, exercise, and medications and limited evidence of improvement on those recommended treatments alone. In addition, a 1-month trial may be appropriate to permit the treater to study the effects and benefits of its use. The records show that the patient has not trialed an IF unit. MTUS Guidelines recommend a 1-month trial to determine its efficacy in terms of pain relief and functional improvement before a purchase can be made. Recommendation is for denial.

EMG bilateral lower extremities: Overturned

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

MAXIMUS guideline: Decision based on MTUS ACOEM Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back chapter on EMG and NCV

Decision rationale: This patient presents with neck, back, and bilateral upper extremity pain. The treater is requesting an EMG OF THE BILATERAL LOWER EXTREMITIES. The ACOEM Guidelines page 303 states that electromyography (EMG including H-reflex test may be useful to identify subtle focal neurologic dysfunction in patients with low back symptoms lasting more than 3 or 4 weeks). In addition, ODG does not recommend NCV. There is minimal justification for performing nerve conduction studies when the patient is presumed to have symptoms on the basis of radiculopathy. The systemic review and meta-analysis demonstrated neurological testing procedures have limited overall diagnostic accuracy in detecting disk herniation with suspected radiculopathy. In the management of spine trauma with radicular symptoms, EMG/NCS often have low combined sensitivity and specificity in confirming root injury. The 01/29/2014 report notes tenderness to palpation in the cervical, thoracic, and lumbar spine with spasms and decreased range of motion. Straight leg raise is positive on the right. Decreased sensation in the right upper extremity median nerve distribution and decreased motor strength in the bilateral lower extremities at 4/5. The treater does not explain why an EMG/NCV of the bilateral lower extremities is warranted. However, given the patient's clinical presentation, the request is reasonable. Recommendation is for authorization.

Nerve conduction studies of bilateral lower extremities: Upheld

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

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 chapter on EMG and NCV

Decision rationale: This patient presents with neck, back, and bilateral upper extremity pain. The treater is requesting an NERVE CONDUCTION STUDIES OF THE BILATERAL LOWER EXTREMITIES. The ACOEM Guidelines page 303 states that electromyography (EMG including H-reflex test may be useful to identify subtle focal neurologic dysfunction in patients with low back symptoms lasting more than 3 or 4 weeks). In addition, ODG does not recommend NCV. There is minimal justification for performing nerve conduction studies when the patient is presumed to have symptoms on the basis of radiculopathy. The systemic review and meta-analysis demonstrated neurological testing procedures have limited overall diagnostic accuracy in detecting disk herniation with suspected radiculopathy. In the management of spine trauma with radicular symptoms, EMG/NCS often have low combined sensitivity and specificity in confirming root injury. The 01/29/2014 report notes tenderness to palpation in the cervical, thoracic, and lumbar spine with spasms and decreased range of motion. Straight leg raise is positive on the right. Decreased sensation in the right upper extremity median nerve distribution and decreased motor strength in the bilateral lower extremities at 4/5. The treater does not explain why an EMG/NCV of the bilateral lower extremities is warranted. EMG may be appropriate given ACOEM recommendations but NCV study is not per ODG guidelines. This patient does not present with any suspicion for peripheral neuropathy or other conditions. Recommendation is for denial.

MRI of Lumbar Spine: Overturned

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

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 chapter, MRIs (magnetic resonance imaging).

Decision rationale: The patient presents with neck, back, and bilateral upper extremity pain. The treater is requesting an MRI OF THE LUMBAR SPINE. The ACOEM Guidelines page 303 on MRI for back pain states that unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and would consider surgery as an option. When the neurologic examination is less clear, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. ODG also states that repeat MRIs are not routinely recommended and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (e.g. tumor infection fracture, nerve compression, and recurrent disk herniation). The records do not show any MRI of the lumbar spine. The treater

does not discuss why an MRI of the lumbar spine is needed. The 01/29/2014 report notes tenderness to palpation in the lumbar spine with spasm and decreased range of motion. Straight leg raise is positive on the right. There is decreased sensation in the right upper extremity, median nerve distribution, and decreased motor strength in the bilateral lower extremities at 4/5. Given the patient's clinical presentation, an MRI of the lumbar spine is reasonable. Recommendation is for authorization.