

Case Number:	CM14-0030688		
Date Assigned:	06/20/2014	Date of Injury:	07/07/2006
Decision Date:	07/24/2014	UR Denial Date:	02/12/2014
Priority:	Standard	Application Received:	03/10/2014

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, Pain Medicine and is licensed to practice in Texas. 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 63 year old female who had a work related injury on 07/07/2006. Mechanism of injury is not documented. Diagnoses included cervical, thoracic, lumbar strains, bilateral shoulder sprain, bilateral elbow sprain, bilateral wrist and knee sprain, depression, and sleep disturbance. On 12/05/13 there was a reevaluation from a previous visit on 12/08/11 in which there was a reevaluation for exacerbation of her neck, back and bilateral upper extremities complaints. Cervical examination showed decreased range of motion. Negative distraction test. Positive compression test. Reflexes were 2+ and symmetrical in upper extremities. Strength was rated 5/5 in upper extremities. She also had negative Phalen and Tinel sign. The most recent clinical documents dated 06/05/14, physical examination showed tenderness to palpation over paraspinal muscles in the cervical spine. Thoracic spine, tenderness to palpation over paraspinal muscles. Trigger points in trapezius. Lumbar spine, tenderness to palpation over paraspinal muscles. No documentation of any neurological deficit. There was a previous utilization review on 02/11/14 non-certified electromyogram/nerve conduction velocity (EMG/NCV) of upper extremities. Non-certified fluriflex. Non-certified Tramadol/Gabapentin /Menthol/Camphor/Capsaicin 8/10/2/.05% (TGHOT). Modified physical therapy to three sessions instead of 12. The injured worker underwent some extracorporeal shockwave treatment, with some benefit. The request was for physical therapy three times a week for four weeks to the cervical thoracic and lumbar spine, EMG/NCS upper extremities, Fluriflex, and TGHOT.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy three times a week for four weeks to cervical thoracic and lumbar spine:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 174, 299. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck, physical therapy, Low back , physical therapy.

Decision rationale: The request was for physical therapy three times a week for four weeks to the cervical thoracic and lumbar spine is not medically necessary. The clinical documentation submitted for review does not support the request. This was an exacerbation of a chronic problem, she has had physical therapy in the past, and should have been on a home program, three visits would have been enough time to re-educate patient in home exercises. As such medical necessity has not been established.

(NCS) Nerve Conduction Study upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

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) Neck, electrodiagnostic studies.

Decision rationale: The request for nerve conduction velocity (NCV) of bilateral upper extremities is not medically necessary. The clinical documents submitted for review do not support the request for NCV of bilateral upper extremities. Reflexes were 2+ and symmetrical in upper extremities. Strength was rated 5/5 in upper extremities. She also had negative Phalen and Tinel sign. No documentation of any neurological deficit. Therefore medical necessity has not been established.

(EMG) Electromyography upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

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) Neck, electrodiagnostic studies.

Decision rationale: The request for electromyogram (EMG) of bilateral upper extremities is not medically necessary. The clinical documents submitted for review do not support the request for EMG of bilateral upper extremities. Reflexes were 2+ and symmetrical in upper extremities.

Strength was rated 5/5 in upper extremities. She also had negative Phalen and Tinel sign. No documentation of any neurological deficit. Therefore medical necessity has not been established.

Fluriflex: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, compound drugs.

Decision rationale: The request for Fluriflex is not medically necessary. The clinical documentation submitted for review as well as current evidence based guidelines do not support the request for Fluriflex. California Medical Treatment Utilization Schedule, the Official Disability Guidelines and United States Food and Drug Administration do not recommend the use of compounded medications as these medications are noted to be largely experimental in use with few randomized controlled trials to determine efficacy or safety. Further, the FDA requires that all components of a transdermal compounded medication be approved for transdermal use. This compound contains: cyclobenzaprine which has not been approved by the FDA for transdermal use. Any compounded product that contains at least one drug (or drug class) that is not recommended and therefore not medically necessary.

TGHot: 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 based on Non-MTUS Citation Official Disability Guidelines (ODG) pain, compound drug.

Decision rationale: The request for TG Hot is not medically necessary. . California Medical Treatment Utilization Schedule, the Official Disability Guidelines and United States Food and Drug Administration do not recommend the use of compounded medications as these medications are noted to be largely experimental in use with few randomized controlled trials to determine efficacy or safety. Further, the FDA requires that all components of a transdermal compounded medication be approved for transdermal use. This compound contains: tramadol which has not been approved by the FDA for transdermal use. Any compounded product that contains at least one drug (or drug class) that is not recommended and therefore not medically necessary.