

Case Number:	CM14-0075745		
Date Assigned:	08/06/2014	Date of Injury:	09/29/2012
Decision Date:	09/12/2014	UR Denial Date:	05/15/2014
Priority:	Standard	Application Received:	05/23/2014

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 Pain Management & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in New York and 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 37 year old male injured on 09/29/12 due to an undisclosed mechanism of injury. Diagnoses include status post blunt head injury, facial contusion, facial laceration with subsequent surgery, nasal trauma, cervical spine sprain/strain, thoracic spine musculoligamentous sprain/strain, lumbar spine musculoligamentous sprain/strain with radiculitis, lumbar spine disc protrusion, left elbow olecranon bursitis, left forearm internal derangement, left forearm/wrist radius fracture status post external fixation with subsequent nonunion, depression/anxiety, sleep disturbance secondary to pain, left wrist triangular fibrocartilage complex (TFCC) tear/ulnar styloid nonunion, status post lumbar spine surgery on 07/17/13, and vision problems. Clinical note dated 04/23/14 indicates the injured worker presented complaining of headaches, neck, mid/upper back, low back and left elbow/forearm pain rated at 6 to 8/10 dependent upon location. Physical examination revealed 2 to 3 tenderness to palpation over the paraspinal muscles of the cervical spine with cervical compression positive, 2 to 3 tenderness to palpation over the paraspinal muscles of the thoracic spine, grade 2 tenderness to palpation over the paraspinal muscles of the lumbar spine with straight leg raise positive bilaterally, grade 2 to 3 tenderness to palpation of the left elbow/forearm/wrist/hand, and no significant findings on neurocirculatory examination. The documentation indicates the injured worker reported a decrease in pain with physical therapy with improved function and activities of daily life (ADLs) by ten percent. Pending authorization for consultation with neurologist, ophthalmologist, and dentist was noted. It is also noted pending authorization for MRI of the lumbar spine and left wrist surgery, prescriptions for Motrin and Flexeril provided. The initial request for retrospective Fluriflex 180 gram, TG Hot 180 gram, electromyography (EMG) bilateral lower extremities, nerve conduction velocity (NCV) bilateral lower extremities,

purchase of an interferential unit, consult with ophthalmologist and neurostimulation therapy date of service 02/12/14 was initially noncertified on 05/15/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for Fluriflex, 180gm, DOS 02/12/14: 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 rationale: As noted in the Chronic Pain Medical Treatment Guidelines, the safety and efficacy of compounded medications has not been established through rigorous clinical trials. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Further, California Medical Treatment Utilization Schedule (MTUS), Food and Drug Administration (FDA), and Official Disability Guidelines (ODG) require that all components of a compounded topical medication be approved for transdermal use. This compound contains flurbiprofen and cyclobenzaprine which have not been approved for transdermal use. In addition, there is no evidence within the medical records submitted that substantiates the necessity of a transdermal versus oral route of administration. Therefore retrospective request for Fluriflex, 180 gram, date of service 02/12/14 is not medically necessary as it does not meet established and accepted medical guidelines.

Retrospective request for TGHOT, 180gm, DOS 02/12/14: 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 rationale: As noted in the Chronic Pain Medical Treatment Guidelines, the safety and efficacy of compounded medications has not been established through rigorous clinical trials. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Further, California Medical Treatment Utilization Schedule (MTUS), Food and Drug Administration (FDA), and Official Disability Guidelines (ODG) require that all components of a compounded topical medication be approved for transdermal use. This compound contains Tramadol and Gabapentin which have not been approved for transdermal use. In addition, there is no evidence within the medical records submitted that substantiates the necessity of a transdermal versus oral route of administration. Therefore, this compound is not medically necessary as it does not meet established and accepted medical guidelines.

Retrospective request for EMG bilateral lower extremities, DOS 02/12/14: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines - Treatment in Workers Compensation, Low Back Procedure Summary (Updated 02/13/2014).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ONLINE VERSION, LOW BACK COMPLAINTS, ELECTROMYOGRAPHY.

Decision rationale: As noted in the California Chronic Pain Medical Treatment Guidelines, needle electromyography (EMG) and H reflex tests to clarify nerve root dysfunction are recommended for the treatment of acute and subacute low back disorders. EMG for clinically obvious radiculopathy in acute, subacute, and chronic radicular pain syndromes (including sciatica) is not recommended. EMG remains helpful in certain situations to include ongoing pain complaints suspected to be of neurological origin, but without clear neurological compromise on imaging study. EMG can then be used to attempt to rule in/out a physiologically important neurological compromise. An abnormal study confirming radiculopathy permits a diagnosis of neuropathic pain (helping with pain management decisions), and may change an American Medical Association (AMA) guides impairment rating. It is worth noting that this test should not be performed in the first month unless there is a desire to document prior (preexisting) neurological compromise. As such, the retrospective request for EMG bilateral lower extremities, date of service 02/12/14 is not medically necessary.

Retrospective request for NCV bilateral lower extremities, DOS 02/12/14: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines - Treatment in Workers Compensation, Low Back Procedure Summary (Updated 02/13/2014).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), LUMBAR & THORACIC, LOW BACK-NERVE CONDUCTION STUDIES.

Decision rationale: As noted in the Official Disability Guidelines (ODG), nerve conduction studies (NCS) are not recommended. There is minimal justification for performing nerve conduction studies when an injured worker is presumed to have symptoms on the basis of radiculopathy. Recent studies demonstrate that neurological testing procedures have limited overall diagnostic accuracy in detecting disc herniation with suspected radiculopathy. As such, the request for retrospective request for nerve conduction velocity (NCV) bilateral lower extremities, date of service 02/12/14 is not medically necessary.

Retrospective request for purchase of an Interferential (IF) Unit, DOS 02/12/14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential current stimulation (ICS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
INTERFERENTIAL CURRENT STIMULATION (ICS) Page(s): 118.

Decision rationale: As noted in the Chronic Pain Medical Treatment Guidelines, interferential units are not recommended as an isolated intervention. There are no standardized protocols for the use of interferential therapy; and the therapy may vary according to the frequency of stimulation, the pulse duration, treatment time, and electrode technique. Criteria for use includes pain is ineffectively controlled due to diminished effectiveness of medications or due to side effects; history of substance abuse; significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; unresponsive to conservative measures. If those criteria are met, then a one month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction. Therefore, this request is not medically necessary.

Retrospective request for Consult with Ophthalmologist, DOS 02/12/14: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines - Treatment in Workers Compensation, Eye Procedure Summary (Updated 02/17/2014).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Office Visits.

Decision rationale: There is no indication in the documentation the patient requires ophthalmology consultation. The clinical documentation failed to provide abnormal objective findings to justify consultation. Additionally, if to be utilized for evaluation of end organ damage, there is no indication other means of assessment or chronic kidney damage has occurred that would warrant assessment. As such, the request for retrospective request for consult with ophthalmologist, date of service 02/12/14 is not medically necessary at this time.

Localized Intense Neurostimulation Therapy (LINT): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Miguel Goreberg, Elad Schiff, Kobi Schwartz, and Elon Eizenberg, "A Novel Image-Guided, Automatic, High Intensity Neurostimulation Device for the Treatment of Nonspecific Low Back Pain", Pain Research and Treatment, vol. 2011, Article ID 152307, 6 pages, 2011.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Neuromuscular electrical stimulation (NMES devices) Page(s): 121 OF 127.

Decision rationale: As noted in the Chronic Pain Medical Treatment Guidelines, neurostimulation therapy is not recommended. Neuromuscular electrical stimulation (NMES) is used primarily as part of a rehabilitation program following stroke and there is no evidence to support its use in chronic pain. There are no intervention trials suggesting benefit from NMES

for chronic pain. As such, the request for Localized Intense Neurostimulation Therapy (LINT) is not medically necessary at this time.