

<b>Case Number:</b>	CM14-0086744		
<b>Date Assigned:</b>	07/23/2014	<b>Date of Injury:</b>	10/29/2013
<b>Decision Date:</b>	09/25/2014	<b>UR Denial Date:</b>	05/06/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/09/2014

### 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 Nevada 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 56-year-old female who was reportedly injured on October 29, 2013. The mechanism of injury was not listed in these records reviewed. The most recent progress note dated June 11, 2014, indicated that there were ongoing complaints of neck pain, right upper extremity pain and low back pain. The physical examination demonstrated a hypertensive (171/86) individual with a marked decrease in grip strength in the right. There was tenderness to palpation of the cervical spine with some muscle spasm noted. A decrease in cervical spine range of motion was reported. Upper extremity strength was reported to be 5/5 and deep tendon reflexes were intact and equal bilaterally. There was tenderness the lumbar spine, with no muscle spasm reported. Diagnostic imaging studies were not reported. Previous treatment included medications and conservative care. A request was made for topical preparations, interferential unit, a urine drug screen and an extracorporeal shock wave therapy and was not certified in the pre-authorization process on May 6, 2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Fluriflex 180gm:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 111.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112.

**Decision rationale:** This is a compounded topical preparation that includes a non-steroidal (flurbiprofen) and a muscle relaxant (cyclobenzaprine). As noted in the California Medical Treatment Utilization Schedule, such compounded preparations are "largely experimental" and that any compound product, that contains at least one drug, is not recommended, the overall product not recommended. There is no clinical indication presented for a muscle relaxant when noting the diagnosis offered. As such, the medical necessity for this topical preparation has not been established. Therefore, this request is not medically necessary.

**TG HOT 180 gm:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 111.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112.

**Decision rationale:** California Medical Treatment Utilization Schedule Chronic Pain Guidelines state that topical analgesics are "largely experimental" and "any compound product, that contains at least one drug (or drug class), that is not recommended, is not recommended". The guidelines indicate gabapentin is not recommended for topical application. Additionally, the guidelines recommend the use of capsaicin only as an option for patients who are intolerant of other treatments and there is no indication that an increase over a 0.025% formulation would be effective. There is no documentation in the records submitted indicating the claimant was intolerant of other treatments. The request for topical TGHOT is not in accordance with the California Medical Treatment Utilization Schedule guidelines. Therefore, the request for TG Hot Cream is not medically necessary.

**Interferential 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 Page(s): 118-120.

**Decision rationale:** California Medical Treatment Utilization Schedule guidelines do not support interferential therapy as an isolated intervention. Guidelines will support a one-month trial in conjunction with physical therapy, exercise program and a return to work plan if chronic pain is ineffectively controlled with pain medications or side effects to those medications. In that there has not been any demonstrated attest that using this and the physical therapy, there is no clinical indication for the medical necessity of this device. Review, of the available medical records, fails to document any of the criteria required for an interferential unit one-month trial. As such, this request is not medically necessary.

**urine drug screen: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines opioids  
Page(s): 78.

**Decision rationale:** As outlined in the California Medical Treatment Utilization Schedule, there is support for drug screening as part of ongoing chronic opioid management protocols. However, the medications being employed, the suspicions or indications necessary to conduct such a study, abuse potential, and other parameters are needed to be addressed prior to establishing the clinical indication for this testing. Therefore, based on the limited clinical information presented for review, this is not medically necessary.

**Extracorporeal shock wave therapy #4 to the right ankle: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Shoulder chapter, updated July 2014.

**Decision rationale:** As outlined in the Official Disability Guidelines, the only noted efficacy for this type of intervention is for a calcifying tendinitis of the shoulder or a plantar faciitis. There is no indication in the medical records presented for review that either of these diagnoses exists. As such, the medical necessity for this intervention cannot be established. Therefore, this request is not medically necessary.