

Case Number:	CM14-0179335		
Date Assigned:	12/03/2014	Date of Injury:	12/04/2013
Decision Date:	01/13/2015	UR Denial Date:	09/30/2014
Priority:	Standard	Application Received:	10/28/2014

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 Pain Management 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:

This is a female patient with the date of injury of December 4, 2013. A Utilization Review dated September 26, 2014 recommended non-certification of interferential unit for the cervical spine/right shoulder only, motorized cold therapy for the cervical spine/right shoulder only, topical compound creams Flurbiprofen/Capsaicin/Camphor 10%/0.025%/2%/1% (120gm), topical compound creams Ketoprofen/Cyclobenzaprine/Lidocaine 10%/3%/5% (120gm), and Prilosec 20mg #60. A Visit Note dated September 19, 2014 identifies Subjective Complaints of pain in the right shoulder, right elbow, and right wrist. She reported radiating pain and numbness to her hand and fingers on the right side. Physical Examination identifies tenderness to palpation of the cervical spine with decreased range of motion and spasm. She had hypoesthesia in a C6, C7, and T1 dermatomal distribution. Tenderness to palpation to the right shoulder and decreased range of motion with a positive impingement sign. Tenderness to palpation of the left shoulder with decreased range of motion and a positive impingement sign, as well as tenderness to the right lateral epicondyle. She had a positive Finkelstein's and positive Tinel's sign at the right wrist with paresthesia of the right hand and restricted right hand range of motion. Diagnoses identify cervical radiculitis, left shoulder sprain/strain, right shoulder impingement syndrome, right elbow epicondylitis, right wrist sprain/strain, and right hand sprain/strain with neuralgia. Treatment Plan identifies interferential unit, motorized cold therapy unit, topical compounded creams, and Prilosec.

IMR ISSUES, DECISIONS AND RATIONALES

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

Motorized cold therapy for the cervical spine/right shoulder only: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Treatment Index, 12th Edition (web), 2014, Neck and Upper Back and Shoulder chapters, Continuous-flow cryotherapy

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Shoulder Chapters, Continuous-flow cryotherapy section

Decision rationale: Regarding the request for motorized cold therapy for the cervical spine/right shoulder only, California MTUS does not address the issue. Regarding the neck, ODG states it is not recommended at the neck. Regarding the shoulder, ODG cites that continuous-flow cryotherapy is recommended as an option after surgery for up to 7 days, including home use, but not for non-surgical treatment. Within the documentation available for review, it is not specified if the unit is intended post-surgical or for non-surgical treatment. Nonetheless, if the unit rental was intended for post-surgical therapy, there is no indication that the patient has had recent shoulder surgery. Additionally, the request is open-ended, and there is no provision for modification. As such, the currently requested motorized cold therapy for the cervical spine/right shoulder only is not medically necessary.

Prilosec 20 mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms and cardiovascular risk Page(s): 68, 70.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69 of 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Proton Pump Inhibitors (PPIs)

Decision rationale: Regarding the request for Omeprazole (Prilosec), California MTUS states that proton pump inhibitors are appropriate for the treatment of dyspepsia secondary to NSAID therapy or for patients at risk for gastrointestinal events with NSAID use. Within the documentation available for review, there is no indication that the patient has complaints of dyspepsia secondary to NSAID use, a risk for gastrointestinal events with NSAID use, or another indication for this medication. In light of the above issues, the currently requested omeprazole (Prilosec) is not medically necessary.

Compound topical cream: Flurbiprofen/Capsaicin/Camphor 10/0.025%/2%/1% (120 g): 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 Page(s): 111-113 of 127.

Decision rationale: Regarding request for compound topical cream:

Flurbiprofen/Capsaicin/Camphor 10/0.025%/2%/1% (120 g), Chronic Pain Medical Treatment Guidelines state that any compounded product that contains at least one drug or drug class that is not recommended, is not recommended. Regarding the use of topical non-steroidal anti-inflammatory, guidelines state that the efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the 1st 2 weeks of treatment osteoarthritis, but either not afterwards or with the diminishing effect over another two-week period. Regarding use of Capsaicin, guidelines state that it is recommended only as an option for patients who did not respond to or are intolerant to other treatments. Within the documentation available for review, there is no indication that the patient is unable to tolerate oral NSAIDs. Oral NSAIDs have significantly more guideline support compared with topical NSAIDs. Additionally, there is no indication that the topical NSAID is going to be used for short duration. Additionally, there is no indication that the patient has been intolerant to or did not respond to other treatments prior to the initiation of capsaicin therapy. In the absence of clarity regarding those issues, the currently requested compound topical cream: Flurbiprofen/Capsaicin/Camphor 10/0.025%/2%/1% (120 g) is not medically necessary.

Compound topical cream: Ketoprofen/Cyclobenzaprine/Lidocaine (10%/3%/5%) 120 g:
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 Page(s): 111-113 of 127.

Decision rationale: Regarding request for compound topical cream:

Ketoprofen/Cyclobenzaprine/Lidocaine (10%/3%/5%) 120 g, Chronic Pain Medical Treatment Guidelines state that any compounded product that contains at least one drug or drug class that is not recommended, is not recommended. Regarding the use of topical non-steroidal anti-inflammatory, guidelines state that the efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the 1st 2 weeks of treatment osteoarthritis, but either not afterwards or with the diminishing effect over another two-week period. Regarding the request for topical Cyclobenzaprine, Chronic Pain Medical Treatment Guidelines state that topical muscle relaxants are not recommended. They go on to state that there is no evidence for the use of any muscle relaxants as a topical product. Regarding topical Lidocaine, Chronic Pain Medical Treatment Guidelines recommend the use of topical Lidocaine for localized peripheral pain after there has been evidence of a trial of the 1st line therapy such as tri-cyclic antidepressants, SNRIs, or antiepileptic drugs. Guidelines go on to state that no commercially approved topical formulations of Lidocaine cream, lotion, or gel is indicated for neuropathic pain. Within the documentation available for review, there is no indication that the

patient is unable to tolerate oral NSAIDs. Oral NSAIDs have significantly more guideline support compared with topical NSAIDs. Additionally, there is no indication that the topical NSAID is going to be used for short duration. Additionally, there is no documentation of localized peripheral pain with evidence of failure of first-line therapy as recommended by guidelines prior to the initiation of topical lidocaine. Finally, guidelines do not support topical muscle relaxants and lidocaine in creams. In light of these issues, the currently requested compound topical cream: Ketoprofen/Cyclobenzaprine/Lidocaine (10%/3%/5%) 120 g is not medically necessary.

Interferential unit for the cervical spine/right shoulder only: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-120 of 127.

Decision rationale: Regarding the request for Interferential unit for the cervical spine/right shoulder only, CA MTUS Chronic Pain Medical Treatment Guidelines state that interferential current stimulation is not recommended as an isolated intervention. They go on to state that patient selection criteria if interferential stimulation is to be used anyways include pain is ineffectively controlled due to diminished effectiveness of medication, side effects or history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercises, or unresponsive to conservative treatment. If those criteria are met, then in one month trial may be appropriate to study the effects and benefits. With identification of objective functional improvement, additional interferential unit use may be supported. Within the documentation available for review, there is no indication that the patient has met the selection criteria for interferential stimulation (pain is ineffectively controlled due to diminished effectiveness of medication, side effects or history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercises, or unresponsive to conservative treatment). In light of the above issues, the currently requested Interferential unit for the cervical spine/right shoulder only is not medically necessary.