

Case Number:	CM14-0191077		
Date Assigned:	11/25/2014	Date of Injury:	09/26/2013
Decision Date:	01/09/2015	UR Denial Date:	10/31/2014
Priority:	Standard	Application Received:	11/17/2014

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 & Rehabilitation 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 52-year-old male with a 9/26/13 date of injury. The patient injured his upper back, right wrist/hand, low back, right hip, right knee, and right ankle/foot when he slipped and fell while stepping off a plastic crate. According to a handwritten and largely illegible progress report dated 9/23/14, it appears that the patient complained of numbness and tingling in both lower extremities. The pain was increased with walking and activities of daily living and decreased to a 5/10 with the use of medications. His thoracic and lumbar spine pain was rated as a 3/10. It was noted that the right knee, right ankle, and right wrist had pain. Objective findings: increased ranges of motion with moderate improvement from medications, mild paraspinal tenderness. Diagnostic impression: thoracic spine myospasms, lumbar spine MLDP/DD/NFS, rule out radiculopathy. Treatment to date: medication management, activity modification, and physical therapy. A UR decision dated 10/31/14 denied the request for Localized Intensive Neurostimulation Treatment and NM diagnostic procedure, ESWT, initial high complexity neurospine evaluation, tramadol, Compound: MPC1- Flurbiprofen 20% Baclofen 10%/Dexamethasone 2% in cream base; QTY: 30gm, 210grams, and Compound: NPHCC2-Dextromethorphan 5% Gabapentin 5%/Bupivacaine 2.5%/Menthol 1%/Camphor 1%, 210grams. Regarding LINT, there is no documentation provided identifying that this treatment provides improved outcomes as compared to other treatment options that are evidence-based and supported, and there is no documentation identifying the medical necessity of this request. Regarding ESWT, the medical records provided do not document clinical and imaging findings to support the presence of calcifying tendinitis of the shoulder. Regarding neurospine evaluation, there are no specific objective findings and no rationale provided to indicate that specialist consultation would be warranted at this time. Regarding tramadol, there is no rationale for the prescribing of an ER medication for as needed use as this is not the intent of extended-release

medications. Regarding topical medications, the conditions for possible use have not been documented. Topical use of muscle relaxants, antiepilepsy drugs, and lidocaine are not supported. There is no rationale for the use of topical dexamethasone in the patient's cited injuries.

IMR ISSUES, DECISIONS AND RATIONALES

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

Localized Intensive Neurostimulation Treatment and NM diagnostic procedure: 1/ to the thoracic spine; one (1) time a week for four (4) weeks and 2/ to lumbar spine; one (1) time a week for four (4) weeks: 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) Low Back Chapter, Hyperstimulation analgesia

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 - Hyperstimulation Analgesia

Decision rationale: CA MTUS does not address this issue. ODG states that LINT is not recommended until there are higher quality studies. Initial results are promising, but only from two low quality studies sponsored by the manufacturer. However, in the present case, requesting provider does not establish circumstances that would warrant LINT therapy despite lack of positive evidence. There is no documentation that this patient has failed conservative measures of treatment. Therefore, the request for Localized Intensive Neurostimulation Treatment and NM diagnostic procedure: 1/ to the thoracic spine; one (1) time a week for four (4) weeks and 2/ to lumbar spine; one (1) time a week for four (4) weeks is not medically necessary.

Extracorporeal shockwave therapy (ESWT): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

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 - ESWT

Decision rationale: ODG states that shockwave therapy is not recommended. The available evidence does not support the effectiveness of ultrasound or shock wave for treating LBP. In the absence of such evidence, the clinical use of these forms of treatment is not justified and should be discouraged. However, in the present case, there is no documentation as to what region of the body ESWT is being requested for. There is no documentation that this patient has failed conservative measures of treatment. The requesting physician failed to establish compelling circumstances identifying why ESWT for the low back unit be required despite adverse

evidence. Therefore, the request for extracorporeal shockwave therapy (ESWT) is not medically necessary.

Initial high complexity Neurospine evaluation of the thoracic spine and lumbar spine:

Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM for Independent Medical Examinations and Consultations regarding referrals, Chapter 7

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Clinical Topics. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 6 - Independent Medical Examinations and Consultations, page(s) 127, 156 Official Disability Guidelines (ODG) Pain Chapter - Office Visits

Decision rationale: CA MTUS states that consultations are recommended, and a health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present or when the plan or course of care may benefit from additional expertise. However, in the present case, there is no documentation of a differential diagnoses provided. There is no specific rationale provided as to why this patient requires a neurospine evaluation. Therefore, the request for Initial high complexity Neurospine evaluation of the thoracic spine and lumbar spine is not medically necessary.

Tramadol 150 mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opiates Page(s): 78-81.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines do not support ongoing opioid treatment unless prescriptions are from a single practitioner and are taken as directed; are prescribed at the lowest possible dose; and unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. However, in the medical records provided for review, it is unclear how long this patient has been taking tramadol. There is no documentation of significant pain reduction or improved activities of daily living. Guidelines do not support the continued use of opioid medications without documentation of functional improvement. In addition, there is no documentation of lack of aberrant behavior or adverse side effects, an opioid pain contract, urine drug screen, or CURES monitoring. Therefore, the request for Tramadol 150mg #30 is not medically necessary.

Compound: MPC1- Flurbiprofen 20% Baclofen 10%/Dexamethasone 2% in cream base;
QTY: 30gm, 210grams: 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): 25, 28, 111-113.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines state that ketoprofen, lidocaine (in creams, lotion or gels), capsaicin in anything greater than a 0.025% formulation, baclofen, Boswellia Serrata Resin, and other muscle relaxants, and gabapentin and other antiepilepsy drugs are not recommended for topical applications. However, in the present case, guidelines do not recommend the use of the NSAID, flurbiprofen or baclofen in a topical formulation. In addition, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. A specific rationale identifying why this topical compounded medication would be required in this patient despite lack of guideline support was not provided. Therefore, the request for Compound: MPC1- Flurbiprofen 20% Baclofen 10%/Dexamethasone 2% in cream base; QTY: 30gm, 210grams is not medically necessary.

Compound: NPHCC2- Dextromethorphan 5% Gabapentin 5%/Bupivacaine 2.5%/Menthol 1%/Camphor 1%, 210grams: 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): 25, 28, 111-113.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines state that ketoprofen, lidocaine (in creams, lotion or gels), capsaicin in anything greater than a 0.025% formulation, baclofen, Boswellia Serrata Resin, and other muscle relaxants, and gabapentin and other antiepilepsy drugs are not recommended for topical applications. However, in the present case, guidelines do not recommend the use of gabapentin or bupivacaine in a topical formulation. In addition, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. A specific rationale identifying why this topical compounded medication would be required in this patient despite lack of guideline support was not provided. Therefore, the request for Compound: NPHCC2- Dextromethorphan 5% Gabapentin 5%/Bupivacaine 2.5%/Menthol 1%/Camphor 1%, 210grams is not medically necessary.