

Case Number:	CM15-0162054		
Date Assigned:	08/28/2015	Date of Injury:	05/07/2015
Decision Date:	10/13/2015	UR Denial Date:	08/10/2015
Priority:	Standard	Application Received:	08/18/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: New York

Certification(s)/Specialty: Anesthesiology

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 60 year old male, who sustained an industrial injury on 5-7-2015. The mechanism of injury is not described. The current diagnoses are status post blunt head injury, lumbar spine musculoligamentous sprain-strain, status post lumbar spine disc protrusions with radiculopathy, left shoulder sprain-strain-tendinosis, right wrist sprain-strain, rule out right wrist carpal tunnel syndrome, right knee sprain-strain, and rule out right knee meniscal tear. According to the progress report dated 7-15-2015, the injured worker complains of low back, left shoulder, and right knee pain. In addition, he reports pain and numbness in the right wrist. On a subjective pain scale, he rates his low back pain 6 out of 10, which has decreased from 7 out of 10 on his last visit, left shoulder 5 out of 10, decreased from 7 out 10, right wrist 2 out of 10, decreased from 6 out of 10, and right knee 6 out of 10, which remained the same. The physical examination of the lumbar spine reveals tenderness to palpation over the paraspinal muscles, spasm, and restricted range of motion. Examination of the left shoulder reveals tenderness to palpation, restricted range of motion, and positive supraspinatus and impingement tests. Examination of the right wrist reveals tenderness to palpation. Examination of the right knee reveals tenderness to palpation, restricted range of motion, and positive McMurray's test. The current medications are not specified. Treatment to date has included medication management and physical therapy. Work status is described as temporary total disability. A request for Flurbi cream, Gabacyclotram, motorized hot-cold unit, EMG-NCV of the bilateral upper extremities, and 12 physical therapy sessions to the lumbar spine, left shoulder, right wrist, and right knee has been submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

12 Physical therapy sessions for the lumbar spine, left shoulder, right wrist and right knee:
Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: The CA MTUS Chronic Pain Medical Treatment Guidelines suggest physical can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. In this case, the guidelines state that medical necessity for any physical therapy beyond the initial course depends on functional improvement. Although, there is documentation of measurable decrease in the intensity of pain per the VAS scale there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result. The work status is described as 'temporary total disability', which implies a complete lack of functional improvement. In addition, the injured worker should have had sufficient experience with physical therapy to perform independent exercise and self-care by now with previous physical therapy. Therefore, based on the CA MTUS guidelines and submitted medical records, the request for 12 physical therapy sessions to the lumbar spine, left shoulder, right wrist and right knee is not medically necessary.

EMG/NCV of bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178-182.

Decision rationale: The CA ACOEM Medical Treatment Guidelines state that when the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. An EMG is recommended for diagnosis of nerve root involvement if findings of history,

physical exam, and imaging studies are consistent and not recommended for clinically obvious radiculopathy confirmed by imaging. In this case, the submitted medical records failed to provide adequate clinical findings to support electrodiagnostic studies of the bilateral upper extremities. On examination, there was no evidence of neurologic dysfunction such as sensory, reflex, or motor system changes to the upper extremities. Therefore, based on ACOEM guidelines and submitted medical records, the request for EMG/NCV of the bilateral upper extremities is not medically necessary.

Flurbi (nap) cream - LA (Flurbiprofen 20%, Lidocaine 5%, Amitriptyline 5%) 180gm:
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): 111-113.

Decision rationale: According to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, local anesthetics or antidepressants. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. In this case, there is no documentation provided necessitating Flurbi (NAP) cream. This topical cream contains: Flurbiprofen 20%, Amitriptyline 5%, and Lidocaine 5%. According to the guidelines, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Flurbiprofen and Amitriptyline agents are not currently FDA approved for a topical application. Flurbiprofen, used as a topical NSAID, has been shown in a meta-analysis to be superior to placebo during the first two weeks of treatment for osteoarthritis but either not afterward, or with diminishing effect, over another two-week period. In addition, topical lidocaine, only in the form of the Lidoderm patch, is indicated for neuropathic pain. Therefore, any topical agent with lidocaine is not recommended if it is not Lidoderm. In this case, there is no documentation that the injured worker has failed a trial of oral antiepileptic and antidepressant medications to support the use of topical analgesics as required by the CA MTUS. In addition, the guidelines note that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Medical necessity for the requested topical compounded medication has not been established. The requested topical cream is not medically necessary.

Gabacyclotram (Gabapentin 10%, Cyclobenzaprine 5%, Tramadol 10%) 180gm: 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): 111-113.

Decision rationale: According to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, muscle relaxants, local anesthetics or antidepressants. Guidelines indicate that any compounded product that contains at least 1 non-recommended drug (or drug class) is not recommended for use. In this case, the requested compounded topical agent is Gabapentin, Cyclobenzaprine, Tramadol (GabaCycloTram) cream. Cyclobenzaprine is not FDA approved for use as a topical application. There is no evidence for the use of any muscle relaxant as a topical agent. In addition, Gabapentin and Tramadol are not FDA approved for a topical application. There is no peer-reviewed literature to support its use. In addition, there is no documentation that the injured worker has failed a trial of oral antiepileptic and antidepressant medications to support the use of topical analgesics as required by the CA MTUS. Therefore, based on MTUS guidelines and submitted medical records, the request for retrospective GabaCycloTram is not medically necessary.

Motorized hot and cold unit: 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), Knee & Leg, 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) Knee & Leg: Continuous-flow cryotherapy.

Decision rationale: According to the Official Disability Guidelines cryotherapy is recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries (e.g., muscle strains and contusions) has not been fully evaluated. In this case, continuous flow cryotherapy is not recommended for non-surgical treatment. The submitted medical records failed to provide documentation regarding recent or upcoming surgery. Therefore, based on the Official Disability Guidelines and submitted medical records, the request for motorized hot and cold unit is not medically necessary.