

Case Number:	CM15-0198555		
Date Assigned:	10/13/2015	Date of Injury:	04/30/2015
Decision Date:	11/30/2015	UR Denial Date:	09/21/2015
Priority:	Standard	Application Received:	10/09/2015

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: Texas, New York, California
 Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 applicant is a represented 57-year-old who has filed a claim for shoulder and elbow pain reportedly associated with an industrial injury of April 30, 2015. On multiple Utilization Review reports dated September 21, 2015, the claims administrator failed to approve request for prime interferential unit stimulator device, tramadol, and a topical-compounded cream. On August 19, 2015, the applicant reported ongoing complaints of shoulder, wrist, and elbow pain. The applicant had received earlier extracorporeal shockwave therapy and physical therapy, the treating provider reported. The applicant had open reduction and internal fixation of the distal radial fracture, the treating provider acknowledged. Tramadol, physical therapy, and topical compounds in the question were endorsed as was the interferential stimulator device also at issue. The applicant was placed off of work, on total temporary disability. There was no mention of the applicant's has previously employed the interferential stimulator in question on a trial basis.

IMR ISSUES, DECISIONS AND RATIONALES

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

Prime Interferential Unit (IF 400) (purchase): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: No, the request for a prime interferential unit was not medically necessary, medically appropriate, or indicated here. As noted on page 120 of MTUS Chronic Pain Medical Treatment Guidelines, an interferential stimulator device should be furnished on a purchase basis only in applicants in whom there is evidence of increased functional improvement, less reported pain, and evidence of medication during an earlier one-month trial of the same. Here, however, the attending provider prescribed and/or dispensed the device in question on August 19, 2015 without first having the applicant undergo a one-month trial of the device at issue. Therefore, the request was not medically necessary.

Flurbi (NAP) Cream Flurbiprofen 20%/Lidocaine 5%/Amitriptyline 5% 180gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: Similarly, the request for a flurbiprofen-lidocaine-amitriptyline containing topical compound was likewise not medically necessary, medically appropriate, or indicated here. As noted on attending provider's August 19, 2015 progress note, the applicant's primary pain generator was, in fact, shoulder pain; however, page 112 of the MTUS Chronic Pain Medical Treatment Guidelines notes that there is "little evidence" to utilize topical NSAIDs such as flurbiprofen, i.e., the primary ingredient in the compound, for the shoulder, i.e., the primary pain generator here. Since the primary ingredient in the compound was not recommended, the entire compound was not recommended, per page 111 of the MTUS Chronic Pain Medical Treatment Guidelines. Therefore, the request was not medically necessary.

Tramadol 50mg every 12 hours as needed #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

Decision rationale: Finally, the request for tramadol, a synthetic opioid, was likewise not medically necessary, medically appropriate, or indicated here. As noted on page 80 of the MTUS Chronic Pain Medical Treatment Guidelines, the cardinal criteria for continuation of opioid therapy include evidence of successful return to work, improved functioning, and/or reduced pain achieved as a result of the same. Here, however, the applicant was placed off of work, on total temporary disability, on August 19, 2015 office visit at issue. The attending

provider failed to outline quantifiable decrements in pain or meaningful, material improvements in function (if any) effected as a result of ongoing tramadol usage on that date. Therefore, the request was not medically necessary.