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| Case Number: | CM15-0206400 | | |
| Date Assigned: | 10/22/2015 | Date of Injury: | 11/04/2010 |
| Decision Date: | 12/24/2015 | UR Denial Date: | 09/22/2015 |
| Priority: | Standard | Application Received: | 10/19/2015 |

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: Connecticut, California, Virginia

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 injured worker is 61 year old female who sustained an industrial injury on November 04, 2010. She is with surgical history of: low back surgeries times three 1999, 2001 times two. The worker is being treated for: depressive disorder, not otherwise specified with anxiety, psychological factors affecting medical condition; cervical trapezius strain. Subjective: November 04, 2010, she reported "pain and stiffness in the neck and shoulder blades." January 20, 2011, she reported "constant severe neck pain," also reports she is unable to drive. February 05, 2013, she reported initial complaint of neck, shoulders, upper extremities, internal system (mouth, teeth, digestive, sleep disturbances, headaches), psyche. December 19, 2013 she reported "burning pain, spasm at shoulder to finger with tingling." Objective: November 04, 2010, assessment noted "there is no radiating pain or parasthesia's in the upper extremities." Cervical muscles and trapezius between scapulae noted moderately tender and cervical spine range of motion approximately 50% normal and with slow motions; strength to upper extremities WNL. December 19, 2013, assessment noted the patient with diffuse weakness of the upper extremity, particularly on the C7 with triceps. Deep tendon reflexes are found absent on the triceps or brachial radialis. There is no equivocal Hawkin's. Medications: November 04, 2010: Motrin, Robaxin. January 20, 2011: Robaxin, Norco, and Motrin. February 04, 2011: Norco, Flexeril, Voltaren, Prilosec. February 05, 2013: prescribed Buspar, Prosom, and Prozac. Diagnostics: MRI cervical spine January 2011. Treatments: Initial evaluation February 05, 2013 6 CBT sessions, 4 biofeedback sessions and 2 additional medication management sessions, worker noted refusing "modified duty prescription"; acupuncture. On August 27, 2015 a request was

made for compound topical cream containing Flurbiprofen, Lidocaine, and Amitriptyline, a second topical compound cream with Tramadol, Capsaicin, Menthol, Camphor, Gabapentin, and Flexeril, Solace stimulation unit with one year's supply and electrodes leads and wires which were noncertified by Utilization review on September 22, 2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flurbiprofen/Lidocaine/Amitriptyline cream: 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: The MTUS guidelines on Topical Analgesics describe topical treatment as an option, however, topicals are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The MTUS states specifically that any compound product that contains at least one drug (or class) that is not recommended is not recommended. Lidocaine is not recommended as a topical lotion or gel for neuropathic pain, categorizing the requested compound as not recommended by the guidelines; tricyclics are also not appropriate as topicals. The lack of evidence to support use of topical compounds like the one requested makes the requested treatment not medically necessary per the MTUS.

Tramadol/Capsaicin/Menthol/Camphor/Gabapentin/Cyclobenzaprine cream: 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: The MTUS states there is little to no research to support the use of many compounded agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. The MTUS states that muscle relaxers and Gabapentin are not recommended as topical products, therefore, the request cannot be considered medically necessary at this time.

Solace stim unit with up to 12 months of supplies 5 months/convert to purchase (rental or purchase): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation The use of cranial electrotherapy stimulation in the management of chronic pain: A review. Neuro Rehabilitation. 2000; 14(2):85-94.

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

Decision rationale: With respect to chronic pain and according to the MTUS, nerve stimulation is not recommended as a primary treatment modality, but a one-month home-based trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration, for conditions including: Complex regional pain syndrome, neuropathic pain, phantom limb pain, spasticity, and multiple sclerosis. MTUS criteria for use include documentation of pain of at least three months duration and evidence of failure of other modalities in treating pain (including medications). In this case the unit requested is Solace unit and supplies (electrodes, etc.), which is not specifically recommended by the MTUS. This modality may be useful in clinical management of the patient, however, a one-year approval is not required in order to assess for evidence of functional improvement. Therefore at this time and based on the provided records, the request for Solace stim unit and subsequent supplies for one- year cannot be considered medically necessary.

Supplies/electrodes/leadwires/adaptor: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: With respect to chronic pain and according to the MTUS, nerve stimulation is not recommended as a primary treatment modality, but a one-month home-based trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration, for conditions including: Complex regional pain syndrome, neuropathic pain, phantom limb pain, spasticity, and multiple sclerosis. MTUS criteria for use include documentation of pain of at least three months duration and evidence of failure of other modalities in treating pain (including medications). In this case the unit requested is Solace unit and supplies (electrodes, etc.), which is not specifically recommended by the MTUS. This modality may be useful in clinical management of the patient, however, a one-year approval is not required in order to assess for evidence of functional improvement. Therefore at this time and based on the provided records, the request for Solace stim unit and subsequent supplies for one- year cannot be considered medically necessary.