

Case Number:	CM15-0035832		
Date Assigned:	03/04/2015	Date of Injury:	12/30/2014
Decision Date:	05/01/2015	UR Denial Date:	02/18/2015
Priority:	Standard	Application Received:	02/25/2015

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 52 year old female who sustained a work related injury on December 30, 2014, incurring neck, wrists, hands and fingers injuries from repetitive work. She was diagnosed with cervical musculoligamentous strain and sprain with radiculitis, bilateral wrist and hand arthritis and tenosynovitis. Treatment included physical therapy, splinting, work restrictions and pain medications. Currently, the injured worker complained of neck pain with radiation to the shoulders and bilateral upper arms with numbness and tingling in the right hand. On February 18, 2015, a request for one prescription for Flurbi cream (LA) (Flurbiprofen 20%,- Lidocaine 5%,- Amitriptyline 5%), 180 grams; Unknown Tramadol 50 mg; Interferential Unit; one hot and cold unit; one x ray of the cervical spine; and electromyogram/nerve conduction velocity of the bilateral upper extremities, was non-certified by Utilization Review and 12 physical therapy treatments and evaluation for cervical spine and bilateral wrists and hands was modified to a certification of 6 physical therapy treatments and an evaluation for cervical spine and bilateral wrists and hands, noting the California Medical Treatment Utilization Schedule Guidelines and Official Disability Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 prescription for Flurbi (NAP) cream-LA (flurbiprofen 20%-lidocaine 5%-amitriptyline 5%), 180 gm: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Topical Analgesics.

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. 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, there is no documentation provided necessitating Flurbi (nap) cream (flurbiprofen 20%-lidocaine 5%-amitriptyline 5%). Topical Lidocaine, in the formulation of a dermal patch (Lidoderm) is FDA approved for neuropathic pain, and used off-label for diabetic neuropathy. No other Lidocaine topical creams or lotions are indicated for neuropathic or non-neuropathic pain. In addition, there is no documentation of intolerance to other previous oral medications. The medical necessity of the requested compounded medication has not been established. The requested topical analgesic compound is not medically necessary.

Unknown tramadol 50mg: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

Decision rationale: According to the ODG, chronic pain can have a mixed physiologic etiology of both neuropathic and nociceptive components. In most cases, analgesic treatment should begin with acetaminophen, aspirin, and NSAIDs. When these drugs do not satisfactorily reduce pain, opioids for moderate to severe pain may be added. In this case, there is a request for Tramadol 50mg (unknown). However, there is no documentation that the patient failed a trial of non-opioid analgesics. Medical necessity for the requested medication has not been established. The requested treatment with Tramadol is not medically necessary.

IF unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 265, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm, Wrist, and Hand.

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

Decision rationale: According to MTUS, Interferential Current Stimulation (ICS) is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. There are no standardized protocols for the use of interferential therapy. A one-month trial may be appropriate in cases where pain is ineffectively controlled due to diminished effectiveness of medication due to side effects, there is a history of substance abuse, there is significant post-operative pain, or if the patient is unresponsive to conservative measures. There is no indication for use of this treatment. The documentation indicates that there has been limited conservative care to date. The documentation failed to reveal evidence of diminished effectiveness of medications or side effects. Medical necessity for the requested interferential unit has not been established. The requested treatment is not medically necessary.

1 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 -Knee and Leg, Carpal Tunnel syndrome (Acute & Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medscape Internal Medicine- Cold/Heat therapy.

Decision rationale: Cold application, followed by heat therapy, is recommended during the first few days of acute complaints. The documentation indicates that the patient is no longer in the acute phase of injury, and there is no documentation indicating that a heat and cold unit would provide better relief than the application of heat and cold packs. Medical necessity for the requested treatment is not established. The requested treatment is not medically necessary.

1 x-ray of the cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

Decision rationale: The ACOEM guidelines recommend cervical spine films after a 3-4 week period of conservative care and observation fails to improve symptoms. Criteria for imaging studies include emergence of a red flag, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program, and/or clarification of anatomy prior to an invasive procedure. In this case, the patient has undergone limited conservative care and there are no red flags or physical exam evidence of neurologic dysfunction. Medical necessity

for the requested cervical spine films has not been established. The requested imaging study is not medically necessary.

1 EMG/NCV of the 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, Chapter 11 Forearm, Wrist, and Hand Complaints, Chronic Pain Treatment Guidelines EMG/NCV. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) EMG/NCV.

Decision rationale: The California MTUS/ACOEM Guidelines state that electromyography(EMG) and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle, focal neurologic dysfunction in patients with neck or arm problems, or both, lasting more than 3 to 4 weeks. The Official Disability Guidelines further state that nerve conduction studies are recommended if the EMG is not clearly a radiculopathy or clearly negative, or to differentiate radiculopathy from other neuropathies or non-neuropathic processes, if other diagnoses may be likely based on the clinical exam. In this case, the patient had undergone limited conservative care for the cervical spine and bilateral wrists and hands. There were no findings suggestive of neurologic dysfunction in the upper extremities. Medical necessity for the requested EMG/NCV has not been established. The requested studies are not medically necessary.

12 physical therapy evaluation and treatment for cervical spine and bilateral wrists/hands: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy Page(s): 97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical Therapy.

Decision rationale: According to the California MTUS Treatment guidelines, physical therapy (PT) is indicated for the treatment of musculoskeletal pain. 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. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Per the ODG, patients should be formally assessed after a "6-visit trial" to see progress made by patient. Additional treatment would be assessed based on functional improvement and appropriate goals for additional treatment. According to the records, this patient had 4 sessions of physical therapy and there was no documentation indicating that she had a defined functional improvement in her condition. There is no specific indication for the additional 12 PT sessions requested for the cervical spine and

bilateral wrist/hands. Medical necessity for the additional PT visits has not been established.
The requested services are not medically necessary.