

Case Number:	CM15-0059873		
Date Assigned:	04/06/2015	Date of Injury:	01/07/2015
Decision Date:	05/28/2015	UR Denial Date:	03/04/2015
Priority:	Standard	Application Received:	03/30/2015

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: California, Arizona
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 53 year old female, who sustained an industrial injury on 01/07/2015. The mechanism of injury involved cumulative trauma. The injured worker was diagnosed as having possible bilateral carpal tunnel syndrome, cervical disc displacement, bilateral rotator cuff syndrome and left knee pain. Hand magnetic resonance imaging showed bilateral carpal tunnel syndrome and x rays of the neck and back show arthritis. Treatment to date has included physical therapy, acupuncture and medication management. The injured worker presented on 04/07/2015 for a follow-up evaluation. The physician indicated the injured worker had been previously referred for a course of physical therapy, which failed to provide an improvement of symptoms. The injured worker was subsequently referred for a nerve conduction study involving the bilateral hands. The injured worker presented with complaints of right posterior wrist pain, right anterior elbow pain, right anterior shoulder pain, upper thoracic pain, cervical pain, left upper extremity pain, and left anterior knee pain. Upon examination of the cervical spine, there was 25 degree flexion, 20 degree extension, 20 degree left and right lateral flexion, 40 degree left rotation, 30 degree right rotation, and diminished grip strength. Treatment recommendations at that time included a course of acupuncture, a referral to a hand surgeon, an MRI of the cervical spine, a compounded cream, a home interferential stimulator unit, and prescriptions for naproxen 500 mg and Prilosec 20 mg. A Request for Authorization form was then submitted on 04/07/2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the cervical spine: 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): 177-179.

Decision rationale: The California MTUS Guidelines state for most patients presenting with true neck and upper back problems, special studies are not needed unless a 3 or 4 week period of conservative care and observation fails to improve symptoms. In this case, there was no mention of a recent attempt at any conservative management for the cervical spine prior to the request for an imaging study. In addition, there was no evidence of a significant sensory or motor deficit upon examination. There was no evidence of the emergence of any red flags. As the medical necessity has not been established, the request is not medically necessary.

IF unit for home use, sixty day trial: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117-121.

Decision rationale: The California MTUS Guidelines state that interferential current stimulation 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. There should be documentation that pain is ineffectively controlled due to the diminished effectiveness of medications or side effects, a history of substance abuse or significant pain from postoperative conditions. There is no indication that this injured worker has failed to respond to conservative management to include TENS therapy prior to the request for an interferential unit. There was also no evidence of a successful 30 day trial prior to the request for a 60 day trial. Given the above, the request is not medically necessary.

Prilosec 20 mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 72.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

Decision rationale: California MTUS Guidelines state, proton pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with

no risk factor and no cardiovascular disease do not require the use of a proton pump inhibitor, even in addition to a nonselective NSAID. In this case, there was no documentation of cardiovascular disease or increased risk factors for gastrointestinal events. The medical necessity for the requested medication has not been established. Additionally, there is no frequency or quantity listed in the request. As such, the request is not medically appropriate.

Compound: Flurbiprofen 120%/Baclofen 20%/Dexamethasone 2%/Menthol 2%/Camphor 2%/Capsaicin 0.0375%/Hyaluric Acid 020%: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Section Page(s): 118.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

Decision rationale: The California MTUS Guidelines state any compounded product that contains at least one drug that is not recommended, is not recommended as a whole. The only FDA approved topical NSAID is diclofenac. The request for a compounded cream containing flurbiprofen would not be supported. Muscle relaxants are not recommended for topical use. There is also no frequency or quantity listed in the request. Given the above, the request is not medically necessary.

EMG/NCS: 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): 177-179.

Decision rationale: The California MTUS/ACOEM Practice Guidelines state electromyography and nerve conduction velocities may help identify subtle, focal neurologic dysfunction in patients with neck or arm symptoms lasting more than 3 or 4 weeks. There was no mention of a recent attempt at any conservative management prior to the request for an electrodiagnostic study. There was also no documentation of a sensory or motor deficit upon examination. The request as submitted failed to indicate the specific body part. Given the above, the request is not medically necessary.