

Case Number:	CM15-0067428		
Date Assigned:	04/15/2015	Date of Injury:	03/30/2014
Decision Date:	07/16/2015	UR Denial Date:	03/13/2015
Priority:	Standard	Application Received:	04/09/2015

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: New York

Certification(s)/Specialty: Internal 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 was a 62 year old female, who sustained an industrial injury, October 1 2012 and May 30, 2014. The injured worker received the following treatments in the past Anaprox, FCL cream, Tramadol ER, Relafen, Omeprazole, physical therapy, random toxicology laboratory studies. The injured worker was diagnosed with left carpal tunnel syndrome, left shoulder impingement syndrome, cervical disc syndrome, cervical radiculopathy, radial nerve injury, and medial nerve injury lumbar disc syndrome and post concussive headaches. According to progress note of January 24, 2015, the injured workers chief complaint was ongoing neck pain rated at 6 out of 10, upper back pain rated at 6 out of 10, left elbow pain 6 out of 10, left wrist pain 5 out of 10, right knee pain 8 out of 10 and back pain 8 out of 10; 0 being no pain and 10 being the worse pain. The physical exam noted altered gait favoring the right knee. There was tenderness and muscle spasms of the left cervical paraspinal, left sternocleidomastoid, left upper trapezius and midline tenderness at C5-C6 and C6-C7 with decreased range of motion. The treatment plan included prescription for FCL cream, physical therapy for the cervical spine and lumbar spine left shoulder and left wrist, MRI of the left shoulder, cervical spine and left wrist and an X-ray of the lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physiotherapy 2x3 to the cervical spine, lumbar spine, left shoulder and left wrist: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines Physical Medicine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98 - 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical Therapy Chapter.

Decision rationale: Per MTUS and ODG, the use of active treatment, including intensive physical training, versus extensive use of passive modalities, is associated with substantially better clinical outcomes. As time goes, there should be an increase in the active regimen of care or decrease in the passive regimen of care and a fading of treatment of frequency. Documentation indicates that the injured worker has undergone an initial course of physical therapy. Although physician report notes that physical therapy is effective, there is no objective evidence of significant improvement in pain or physical function. Medical necessity for additional therapy has not been established. Per guidelines, the request for Physiotherapy 2x3 to the cervical spine, lumbar spine, left shoulder and left wrist is not medically necessary.

MRI of the left shoulder: 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), MRI Shoulder.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): Special Studies and Diagnostic and Treatment Considerations, pg 207.

Decision rationale: MTUS recommends ordering imaging studies when there is evidence of a red flag on physical examination (e.g., indications of intra-abdominal or cardiac problems presenting as shoulder problems), failure to progress in a strengthening program intended to avoid surgery or clarification of the anatomy prior to an invasive procedure (e.g., a full thickness rotator cuff tear not responding to conservative treatment). The injured worker complains of ongoing left shoulder pain. Chart documentation fails to show any red flags or unexplained physical findings on examination that would warrant additional imaging. The request for MRI of the left shoulder is not medically necessary by MTUS.

MRI of the cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck & Upper Back Injury (Acute & Chronic), MRI Scan's.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): Special Studies and Diagnostic and Treatment Considerations, pg 177.

Decision rationale: MTUS recommends spine x rays in patients with neck pain only when there is evidence of red flags for serious spinal pathology. Imaging in patients who do not respond to treatment may be warranted if there are objective findings that identify specific nerve compromise on the neurologic examination and if surgery is being considered as an option. The injured worker complains of ongoing neck pain. Documentation fails to show objective clinical evidence of specific nerve compromise on the neurologic examination or acute exacerbation of the injured worker's symptoms. The medical necessity for additional imaging has not been established. The request for MRI of the cervical spine is not medically necessary.

MRI of the left wrist: 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), Magnetic resonance imaging (MRI).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): Special Studies and Diagnostic and Treatment Considerations, pg 268. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hand Chapter.

Decision rationale: MTUS and ODG recommend Magnetic resonance imaging (MRI) in the evaluation of chronic wrist pain only when plain films are normal and other conditions such as soft tissue tumors are suspected. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. Documentation lacks evidence indicating a significant change in the injured worker's symptoms or clinical findings. The request for MRI of the left wrist is not medically necessary per guidelines.

X-ray of the lumbar spine with A/P lateral and flexion and Extension Views: 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), Lumbar Radiographs.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): Special Studies and Diagnostic and Treatment Considerations, pg 303.

Decision rationale: MTUS recommends Lumbar spine x rays in patients with low back pain only when there is evidence of red flags for serious spinal pathology, even if the pain has persisted for at least six weeks. Imaging in patients who do not respond to treatment may be warranted if there are objective findings that identify specific nerve compromise on the neurologic examination and if surgery is being considered as an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Documentation fails to show objective clinical evidence of specific nerve compromise on the neurologic examination to support the medical necessity for repeat X-rays. The request for X-ray of the lumbar spine with A/P lateral and flexion and Extension Views is not medically necessary per MTUS.

FCL (Flurbiprofen 20%, Baclofen 2%, Dexamethasone 2%, Menthol 2%, Camphor 2%, Capsaicin 0.0375%, Hyaluronic Acid 0.020%) 180grams: 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.

Decision rationale: MTUS states that use of topical analgesics is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many of these agents. Flurbiprofen is not FDA approved for topical application. MTUS provides no evidence recommending the use of topical Menthol. Furthermore, MTUS states that the use of muscle relaxants as a topical agent is not recommended. Per guidelines, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The request for FCL (Flurbiprofen 20%, Baclofen 2%, Dexamethasone 2%, Menthol 2%, Camphor 2%, Capsaicin 0.0375%, Hyaluronic Acid 0.020%) 180grams is not medically necessary by MTUS.