

Case Number:	CM15-0082371		
Date Assigned:	05/04/2015	Date of Injury:	02/27/2009
Decision Date:	09/09/2015	UR Denial Date:	04/03/2015
Priority:	Standard	Application Received:	04/29/2015

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 (IW) is a 54 year old female who sustained an industrial injury on 02/27/2009. She reported injury to her neck and right shoulder. The injured worker was diagnosed as having cervical spine musculoligamentous sprain/strain rule out herniated nucleus pulposus; left upper extremity radiculopathy; left shoulder internal derangement with partial rotator cuff tear; right shoulder musculoligamentous sprain/strain; anxiety, depression, insomnia, hypertension, diabetes, GI/GERD all secondary to industrial injury. Treatment to date has included therapy, medication and pain management. Currently, the injured worker complains of constant severe neck pain rated 8/10 with radiation to the shoulders down to the bilateral upper extremities and hands with associated numbness and tingling. She also complains of severe bilateral shoulder pain with limited range of motion. In addition, she reports symptoms of anxiety, depression, stress, insomnia, Gastro-intestinal distress, and grinding of the teeth. She also complains of hair loss. Treatment plan includes the following: Physical therapy (cervical spine and left shoulder) Qty: 8.00; Internal medicine consultation Qty: 1.00; Psychological evaluation Qty: 1.00; Voltaren XR 100mg Qty: 30.00; Flurbiprofen 20% cream 120gm Qty: 1.00; Ketoprofen 20%/Ketamine10% cream 120gm Qty: 1.00; Ketoprofen 20%/Ketamine10% cream 120gm Qty: 1.00; IF Unit (indefinite use) Qty: 1.00.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy (cervical spine and left shoulder) qty: 8.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: The prescription for Physical Therapy is evaluated in light of the MTUS recommendations for Physical Therapy MTUS recommends: 1) Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. 2) 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. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. The records indicate the injured worker had no significant functional benefit from prior physical therapy visits. In addition, there is no mention of any significant change of symptoms or clinical findings, or acute flare up to support PT. The request for physical therapy is not medically necessary and appropriate.

Internal medicine consultation qty: 1.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, Chapter 7 Independent Medical Examinations and Consultations, page 127.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter-Office visits.

Decision rationale: Official Disability Guidelines (ODG) recommend office visits as determined to be medically necessary. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment. Physician may

refer to other specialists if diagnosis is complex or extremely complex. Consultation is used to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability. The notes submitted by treating provider do not indicate why referral is needed. Medical records are not clear about any change in injured worker's chronic symptoms. The treating provider does not specify what the concerns are that need to be addressed by the specialist. Given the lack of documentation and considering the given guidelines, the request is not medically necessary

Psychological evaluation qty: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 387-388.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter-Office visits.

Decision rationale: Official Disability Guidelines (ODG) recommend office visits as determined to be medically necessary. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment. Physician may refer to other specialists if diagnosis is complex or extremely complex. Consultation is used to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability. The notes submitted by treating provider do not indicate why referral is needed. Medical records are not clear about any change in injured worker's chronic symptoms. The treating provider does not specify what the concerns are that need to be addressed by the specialist. Given the lack of documentation and considering the given guidelines, the request is not medically necessary

Flurbiprofen 20% cream 120gm qty: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113.

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

Decision rationale: According to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of anti-depressants and anti-convulsants 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, muscle relaxants, local anesthetics or antidepressants. Guidelines indicate that any compounded product that contains at least one non-recommended

drug (or drug class) is not recommended for use. Flurbiprofen is used as a topical NSAID. It has been shown in a meta-analysis to be superior to placebo during the first two weeks of treatment for osteoarthritis but either, not afterward, or with diminishing effect over another two-week period. There are no clinical studies to support the safety or effectiveness of Flurbiprofen in a topical delivery system (excluding ophthalmic). Records do not indicate that injured worker is not able to use oral medications. There is no documentation in the submitted Medical Records that the injured worker has failed a trial of anti-depressants and anti-convulsants. In this injured worker, the medical necessity for the requested topical cream has not been established. Therefore, as per guidelines stated above, the requested topical cream is not medically necessary.

Ketoprofen 20%/Ketamine10% cream 120gm qty:1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113.

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

Decision rationale: According to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of anti-depressants and anti-convulsants 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, muscle relaxants, local anesthetics or anti-depressants. Guidelines indicate that any compounded product that contains at least one non-recommended drug (or drug class) is not recommended for use. There is no documentation in the submitted Medical Records that the injured worker has failed a trial of anti-depressants and anti-convulsants. Based on the currently available medical information for review, there is no documentation why this particular cream is requested; the medical necessity for this cream has not been established.

Gabapentin 10%/Cyclobenzaprine10%/Capsaicin 0.0375% cream 120gm qty: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113.

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

Decision rationale: Topical Analgesics, according to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of anti-depressants and anti-convulsants 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, muscle relaxants, local anesthetics or anti-depressants. Guidelines indicate that any compounded product that contains at least one non-

recommended drug (or drug class) is not recommended for use. As per MTUS There is no evidence for use of any muscle relaxant as a topical product. Gabapentin is not recommended. There is no peer-reviewed literature to support its use. In this injured worker, the medical necessity for the requested topical cream has not been established. Therefore, as per guidelines stated above, the requested topical cream is not medically necessary.

IF Unit (indefinite use) qty: 1.00: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Interferential current stimulation (ICS).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg (Acute & Chronic)--Interferential current therapy (IFC).

Decision rationale: 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. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and post-operative knee pain. The findings from these trials were either negative or non-interpretible for recommendation due to poor study design and/or methodologic issues. In addition although proposed for treatment in general for soft tissue injury or for enhancing wound or fracture healing, there is insufficient literature to support Interferential current stimulation for treatment of these conditions. There are no standardized protocols for the use of interferential therapy; and the therapy may vary according to the frequency of stimulation, the pulse duration, treatment time, and electrode-placement technique. As per Official Disability Guidelines (ODG) Interferential current therapy (IFC) is under study for osteoarthritis and recovery post knee surgery. Not recommended for chronic pain or low back problems. After knee surgery, home interferential current therapy (IFC) may help reduce pain, pain medication taken, and swelling while increasing range of motion, resulting in quicker return to activities of daily living and athletic activities. Based on the currently available information in the submitted Medical Records of this injured worker, and per review of the guidelines, the medical necessity for Interferential Current Stimulation (ICS) unit has not been established. The requested Treatment for Interferential Current Stimulation (ICS) is not medically necessary.