MAXIMUS Federal Services

Case Number:	CM14-0117248		
Date Assigned:	09/16/2014	Date of Injury:	08/27/2004
Decision Date:	10/22/2014	UR Denial Date:	07/01/2014
Priority:	Standard	Application Received:	07/25/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Nevada. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 58 year-old male who was reportedly injured on August 27, 2004. The mechanism of injury is noted as a fall from a forklift type event. The most recent progress note dated May 31, 2014, indicates that there were ongoing complaints of cervical spine, lumbar spine, bilateral upper and lower extremity pain. The physical examination demonstrated a full range of motion of lumbar spine, positively raising at 50, with no motor or sensory losses identified. Diagnostic imaging studies objectified no acute osseous abnormalities. Previous treatment includes medications, physical therapy, and other pain management interventions. A request was made for an MRI and multiple medications and was not certified in the pre-authorization process on July 1, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Magnetic Resonance Imaging (MRI) lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back (Acute and Chronic)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

Decision rationale: Considering the date of injury, the injury sustained, the treatment to date, and the current physical examination, there is insufficient clinical evidence presented to suggest a progressive neurologic disorder or that there is a chronic radicular syndrome that has not been evaluated. Furthermore, there is no indication of clinical change subsequent to the prior assessment. Therefore, based on the medical records presented for review, the request is not medically necessary.

Flurbiprofen 20%, Tramadol 20%, Cyclobenzaprine 4% compound cream: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines 8 C.C.R. 9792.20 - 9792.26. MTUS (Effective July 18, 2009) Page(s): Page 112 of 1.

Decision rationale: MTUS Chronic Pain Guidelines state that topical analgesics are "largely experimental" and "any compound product that contains at least one drug (or drug class) that is not recommended, is not recommended". The guidelines note there is little evidence to support the use of topical NSAIDs (Flurbiprofen) for treatment of osteoarthritis of the spine, hip, or shoulder and there is no evidence to support the use for neuropathic pain. Additionally, the guidelines state there is no evidence to support the use of topical Cyclobenzaprine (a muscle relaxant). The guidelines do not support the use of Flurbiprofen or Cyclobenzaprine in a topical formulation. Therefore, the request for FluriFlex is not medically necessary.

Amitriptyline 10%, Dextromethorphan 10%, Gabapentin 10% compound cream 180g: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26; MTUS (Effective July 18, 2009) Page(s): age 113 of 127..

Decision rationale: MTUS Chronic Pain Guidelines state that topical analgesics are "largely experimental" and that "any compound product that contains at least one drug (or drug class) that is not recommended, is not recommended". Additionally, the guidelines state there is no evidence to support the use of topical gabapentin and recommend against the addition of Gabapentin to other agents. Therefore, the request is not medically necessary.

Terocin patches three (3) boxes: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26; MTUS (Effective July 18, 2009 Page(s): Page 105, 112 of 127.

Decision rationale: Terocin is a topical analgesic containing Lidocaine and Menthol. MTUS guidelines support topical lidocaine as a secondary option for neuropathic pain after a trial of an antiepileptic drug or anti-depressants have failed. There is no evidence-based recommendation or support for Menthol. MTUS guidelines state that topical analgesics are "largely experimental" and that "any compound product that contains at least one drug (or drug class) that is not recommended, is not recommended". As such, the request is not medically necessary.

Multi stim unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009 Page(s): Page 114 of 127.

Decision rationale: Electrotherapy represents the therapeutic use of electricity and is another modality that can be used in the treatment of pain. Transcutaneous electrotherapy is the most common form of electrotherapy where electrical stimulation is applied to the surface of the skin. However, as noted in the MTUS, there is insufficient literature to support such an intervention. Therefore, when considering the date of injury, the injury sustained, the current physical examination, and the parameters noted, in the MTUS the request is not medically necessary.

Aqua relief therapy unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation ACOEM Guidelines, Chapter 12 (Low Back Complaints) (2007) pg 161; Official Disability Guidelines, Knee and Lower Leg (Acute & Chronic)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26; MTUS (Effective July 18, 2009) Page(s): Page 22 of 127.

Decision rationale: MTUS supports aquatic therapy as an alternative to land-based physical therapy. Aquatic therapy (including swimming) minimizes the effects of gravity and is recommended where reduced weight bearing is desirable. Review of the available medical records fails to document why the claimant is unable to participate in land-based physical therapy. As such, the request is not medically necessary.

Ultrasound stimulator: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): Page 123 of 12.

Decision rationale: When noting the date of injury, the injury sustained, the findings identified with the current physical examination, and the parameters outlined in the MTUS relative to ultrasound, there is insufficient clinical data to establish the medical necessity of this intervention. There are minimal gazing made in terms of range of motion or motor function. As such, the medical necessity of this intervention has not been established. Therefore, the request is not medically necessary.