

Case Number:	CM14-0117291		
Date Assigned:	09/23/2014	Date of Injury:	04/01/2014
Decision Date:	10/31/2014	UR Denial Date:	07/21/2014
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 & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in California. 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 53-year-old female who reported an injury on 04/01/2014. The mechanism of injury was due to a slip and fall. The injured worker has diagnoses of cervical sprain/strain, hyperextension/hyperflexion, moderate right shoulder impingement with tendinopathy/possible cuff tear, and L5-S1 discopathy and disc herniation syndrome with radiculopathy. Past medical treatment consisted of injections, acupuncture, physical therapy, and medication therapy. The injured worker has undergone x-rays of the cervical spine, lumbar spine, and right shoulder. On 06/24/2014, the injured worker complained of cervical spine pain. The physical examination of the cervical spine revealed that the injured worker had tenderness at the occipital insertion of the paracervical musculature. There was mild tenderness bilaterally in the trapezius. The midline base of the cervical spine was tender. Neurologic testing was intact. The range of motion revealed a cervical flexion of 40 degrees with discomfort, extension of 30 with significant paracervical discomfort, and an inhibition of rotation to the right and left to only 20 degrees. Reflexes of the cervical spine were intact. Sensation was intact in all upper extremities. It was noted that the injured worker had a mildly positive head compression sign, but the Spurling's maneuver was normal. The medical treatment plan was for the injured worker to continue with acupuncture; have use of intense neurostimulation therapy; and medication therapy. The provider felt that the injured worker required ongoing medical treatment. The Request for Authorization form was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Acupuncture eight (8) visits: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The request for acupuncture is not medically necessary. Acupuncture is used as an option when pain medication is reduced or not tolerated. Guidelines state may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Frequency and duration of acupuncture or acupuncture with electrical stimulation may be performed as follows: (1) the time to produce functional improvement is 3 to 6 treatments; (2) a frequency of 1 to 3 times per week; and (3) an optimum duration of 1 to 2 months. It was noted in the submitted documentation that the injured worker had previous acupuncture. There was no indication of what the outcome of those sessions was; it was noted if it helped with any functional deficits. Additionally, the request as submitted was for acupuncture 8 visits, exceeding the recommended guidelines. Furthermore, it was not indicated what extremity was going to be receiving the acupuncture. Given the above, the injured worker is not within the recommended guidelines. As such, the request is not medically necessary.

Localized intense neurostimulation therapy for the lumbar spine two (2) times a week for three (3) weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Localized High Intensity.

Decision rationale: The request for localized intense neurostimulation therapy is not medically necessary. The Official Disability Guidelines do not recommend LINT examination until there are higher quality studies. Initial results are promising, but only from 2 low quality studies sponsored by the manufacturer. Localized manual high intensity neurostimulation devices are applied to small surface areas to stimulator peripheral nerve endings that are causing the release of endogenous endorphins. This procedure, usually described as hyper stimulation analgesia, has been investigated in several control studies; however, such treatments are time consuming and cumbersome and require previous knowledge of the localized fascia of peripheral nerve endings responsible for low back pain or manual impedance of the back. As the guidelines do not recommend hyper stimulation analgesia, the LINT treatment would not be indicated. As such, the request is not medically necessary.

Fluriflex: 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: The request for Fluriflex is not medically necessary. The California MTUS Guidelines state that transdermal compounds are largely experimental in use with few randomized control trials to determine efficacy or safety. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug (or drug class) that is not recommended, is not recommended. The guidelines state topical NSAIDs are recommended for osteoarthritis and tendinitis, in particular, that of the knee, elbow, or other joints that are amenable to topical treatment; they are recommended for short term use (4 to 12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip, or shoulder. The injured worker's diagnosis was not congruent with guideline recommendations for topical NSAIDs. Additionally, the provider's request for Fluriflex did not indicate the site at which the cream was intended for or the frequency of the medication. Given the above, the injured worker is not within the MTUS recommended guidelines. As such, the request is not medically necessary.

Prilosec: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68.

Decision rationale: The request for Prilosec is not medically necessary. The California MTUS Guidelines recommend proton pump inhibitors for patients who are at risk for gastrointestinal events. The injured worker presented with gastrointestinal complaints of heartburn. The injured worker would benefit from the continued use of Prilosec given her gastrointestinal symptoms. However, the request as submitted did not indicate a dosage, frequency, or duration of the medication. Given the above, the request is not medically necessary.