

Case Number:	CM14-0119573		
Date Assigned:	09/16/2014	Date of Injury:	09/29/2012
Decision Date:	10/15/2014	UR Denial Date:	07/15/2014
Priority:	Standard	Application Received:	07/28/2014

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 Orthopedic Surgery 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:

This 37-year-old male sustained an industrial injury on 9/29/12. Injury occurred due to a robbery incident. Past surgical history was positive for a bilateral L4/5 interlaminar laminotomy on 7/17/13, and left wrist arthroscopic triangular fibrocartilage complex repair and ulnar styloid non-union repair on 5/14/14. Records indicated that initial post-op physical therapy had been approved. A neurologic consult was approved on 5/15/14. The 6/6/14 treating physician report cited subjective complaints of headache, neck, mid-back, upper back, lower back, and left elbow and forearm pain. Numbness was reported in the left wrist and hand. Pain ranged from grade 6-8/10. Physical exam documented cervical, thoracic and lumbar paraspinal tenderness. There was tenderness over the left elbow, forearm, wrist, and hand. The treatment plan included Fluriflex, TGHOT, 12 additional physical therapy visits for the left wrist, MRI of the cervical spine, neurologist consultation, and ophthalmologist consultation. The 7/15/14 utilization review denied the requests for Fluriflex and TGHOT based on an absence of guideline support. The request for additional physical therapy was denied as there was no current status report relative to the left wrist to determine medical necessity. The request for cervical MRI was denied as there was limited documentation of neurologic deficits in the upper extremities. The neurologic consult was denied as it had been previously approved and there were no findings from the certified visit to support an additional consult. The request for the ophthalmologist consult was denied as there was no documentation of significant eye problems to support the medical necessity of this request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fluriflex 180 mg: 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): 111-113.

Decision rationale: Fluriflex is a topical compound containing Flurbiprofen and cyclobenzaprine. The California MTUS guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Topical agents are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Guidelines state that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Guidelines state there is no evidence for use of a muscle relaxant, such as cyclobenzaprine, as a topical product. Flurbiprofen is not on the list of approved topical non-steroidal anti-inflammatory drugs. Given the absence of guideline support for all components of this product, this product is not recommended by guidelines. Therefore, this request is not medically necessary.

TgHot 180 mg: 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): 111-113.

Decision rationale: TGHot is a topical compound containing tramadol, gabapentin and capsaicin. The California MTUS state that any compounded product that contains at least one drug that is not recommended is not recommended. Guidelines indicate that topical analgesics in general are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Capsaicin is supported as an option in patients who have not responded or are intolerant to other treatments. Topical gabapentin is not recommended by the guidelines. There are no high-quality literary studies or guidelines which support the safety or efficacy of tramadol utilized topically. Given the absence of guideline support for all components of this product, this product is not recommended by guidelines. Therefore, this request is not medically necessary

Additional physical therapy of the left wrist, 2 x 6 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints, Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation ODG-TWC

MAXIMUS guideline: Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 22.

Decision rationale: The California Post-Surgical Treatment Guidelines for surgical treatment of triangular fibrocartilage complex injuries suggest a general course of 10 post-operative visits over 10 weeks during the 4-month post-surgical treatment period. An initial course of therapy would be supported for one-half the general course or 5 visits. If it is determined that additional functional improvement can be accomplished after completion of the general course of therapy, physical medicine treatment may be continued up to the end of the postsurgical physical medicine period. Guideline criteria have not been met. The amount of post-op treatment completed is not documented. There is no evidence of functional improvement with the initial course of therapy or a specific residual functional deficit to be addressed. There is no current detailed left wrist physical exam. Therefore, this request is not medically necessary.

MRI of the cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 182. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back Procedure Summary Indications for MRI

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178, 182.

Decision rationale: The California MTUS guidelines provide criteria for ordering cervical spine MRIs that includes emergence of a red flag, physiologic evidence of tissue insult or neurologic dysfunction, failure in a strengthening program intended to avoid surgery, or clarification of anatomy prior to an invasive procedure. Guideline criteria have not been met. There is no current physiologic evidence of tissue insult or neurologic dysfunction, or evidence of a red flag condition. There is no significant change in cervical symptoms and/or findings suggestive of significant pathology to support the medical necessity of imaging. There is no detailed documentation that a recent strengthening program had been tried and failed. There is no indication that an invasive procedure is planned. Therefore, this request for MRI of the cervical spine is not medically necessary

Neurologist consultation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Independent Medical Examinations and Consultations, page(s) 127

Decision rationale: The California MTUS guidelines support referral to a specialist if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. A consultant is usually asked to act in an advisory capacity, but may sometimes take full responsibility for treatment of a patient.

Guideline criteria have not been met. There is no current rationale to support the medical necessity of a neurologist referral in addition to the consultation certified on 5/15/14. Therefore, this request is not medically necessary.

Ophthalmologist consultation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Independent Medical Examinations and Consultations, page(s) 127

Decision rationale: The California MTUS guidelines support referral to a specialist if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. A consultant is usually asked to act in an advisory capacity, but may sometimes take full responsibility for treatment of a patient. Guideline criteria have not been met. There is no documentation of any eye complaints or specific exam findings to support the medical necessity of an ophthalmologist consultation. Therefore, this request is not medically necessary.