

Case Number:	CM14-0212713		
Date Assigned:	12/30/2014	Date of Injury:	10/31/2011
Decision Date:	02/19/2015	UR Denial Date:	11/21/2014
Priority:	Standard	Application Received:	12/19/2014

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. 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: Texas, Illinois

Certification(s)/Specialty: Preventive Medicine, Occupational 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 is a 54 year old female who was injured at work on 10/31/2011. She is reported to be complaining of pain in the upper and mid back, lower back, right shoulder, and left knee. She also complained of pain and numbness in the right wrist, as well as sleep disturbance. The pain is 7/10 in the mid/upper back, versus 8/10 in the last visit; 10/10 in the lower back and knee, unchanged from last visit; 8/10 in the right shoulder, unchanged from last visit; 9/10 right wrist, unchanged from last visit. The physical examination revealed limited range of motion and positive compression test of the cervical spine; limited range of motion of the thoracic and lumbar spine, as well as tenderness and spasms of the paraspinal muscles, positive straight leg raise and trigger points bilaterally; tenderness of the right shoulder, right wrist and left knee; positive Tinel's and phalens signs in the right wrist; and positive posterior drawer sign in the left knee. The worker has been diagnosed of thoracic spine musculoligamentous sprain/strain; Lumbosacral sprain/strain with radiculitis, rule out Lumbosacral spine discogenic disease; right shoulder sprain/strain; right shoulder tendinosis, rule out impingement syndrome; right shoulder adhesive capsulitis, rule out rotator cuff tear; right lateral epicondylitis; right carpal tunnel syndrome; right wrist sprain/strain, triangular cartilage tear per MRI of 01/31/13; left knee sprain, rule out meniscal tear, left knee subluxation; status left knee surgeries with residuals, left knee total replacement; complaints of acid reflux; sleep disturbance; depression . At dispute are the requests for Fluriflex 180gm, and LINT of the lumbar spine 1 x 6.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fluriflex 180gm: 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 based on Non-MTUS Citation <http://www.aquapharm.com/fluoroplex.php>

Decision rationale: The injured worker sustained a work related injury on 10/31/2011. The medical records provided indicate the diagnosis of thoracic spine musculoligamentous sprain/strain; Lumbosacral sprain/strain with radiculitis, rule out Lumbosacral spine discogenic disease; right shoulder sprain/strain; right shoulder tendinosis, rule out impingement syndrome; right shoulder adhesive capsulitis, rule out rotator cuff tear; right lateral epicondylitis; right carpal tunnel syndrome; right wrist sprain/strain, triangular cartilage tear, per MRI of 01/31/13; left knee sprain, rule out meniscal tear, left knee subluxation; status left knee surgeries with residuals, left knee total replacement; complaints of acid reflux; sleep disturbance; and depression. The medical records provided for review does not indicate a medical necessity for Fluriflex 180gm. Fluoroplex is a topical cream containing 1% fluorouracil used in the treatment of actinic (solar) keratoses. The records do not indicate the injured worker has been diagnosed of Actinic (Solar) Keratosis; besides, the MTUS does not recommend the use of any topical analgesic containing a non-recommended agent. Therefore, since fluorouracil is not a recommended agent, the requested treatment is not medically necessary and appropriate.

LINT of the lumbar spine 1 x 6: 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, Low Back Chapter

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 - Lumbar & Thoracic (Acute & Chronic), Hyperstimulation Analgesia

Decision rationale: The injured worker sustained a work related injury on 10/31/2011. The medical records provided indicate the diagnosis of thoracic spine musculoligamentous sprain/strain; Lumbosacral sprain/strain with radiculitis, rule out lumbosacral spine discogenic disease; right shoulder sprain/strain; right shoulder tendinosis, rule out impingement syndrome; right shoulder adhesive capsulitis, rule out rotator cuff tear; right lateral epicondylitis; right carpal tunnel syndrome; right wrist sprain/strain, triangular cartilage tear, per MRI of 01/31/13; left knee sprain, rule out meniscal tear, left knee subluxation; status left knee surgeries with residuals, left knee total replacement; complaints of acid reflux; sleep disturbance; and depression. The medical records provided for review does not indicate a medical necessity for

LINT of the lumbar spine 1 x 6. The MTUS is silent on Lint (Nervomatrix) of the lumbar; but the Official Disability Guidelines (ODG) states it is not recommended until there are higher quality studies. Although the initial results are promising, they are only from two low quality studies sponsored by the manufacturer (Nervomatrix Ltd., Netanya, Israel). The Guidelines states that, "Localized manual high-intensity neurostimulation devices are applied to small surface areas to stimulate peripheral nerve endings (fibers), thus causing the release of endogenous endorphins. This procedure, usually described as hyperstimulation analgesia, has been investigated in several controlled studies. However, such treatments are time consuming and cumbersome, and require previous knowledge of the localization of peripheral nerve endings responsible for low back pain (LBP) or manual impedance mapping of the back, and these limitations prevent their extensive utilization". Therefore, the requested treatment is not medically necessary and appropriate.