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| Case Number: | CM15-0114399 | | |
| Date Assigned: | 06/22/2015 | Date of Injury: | 01/19/2010 |
| Decision Date: | 07/27/2015 | UR Denial Date: | 05/20/2015 |
| Priority: | Standard | Application Received: | 06/15/2015 |

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: Pennsylvania

Certification(s)/Specialty: Internal Medicine, Hospice & Palliative 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 48-year-old female who sustained an industrial injury on 01/19/2010. Mechanism of injury was not documented. Diagnoses include cervical spine disc herniation, thoracic sprain/strain, left elbow contusion, right sprain/strain and bilateral knee meniscus tear. Treatment to date has included diagnostic studies, medications, physiotherapy, and acupuncture. The injured worker has returned to work on 02/23/2015. She is permanent and stationary. There is an unofficial Magnetic Resonance Imaging of the cervical spine in August of 2014, which reveals multiple areas of disc desiccation with disc protrusion and narrowing of the thecal sac. A physician progress note dated 05/13/2015 documents the injured worker has a flare up of neck pain rated 5 out of 10, bilateral knee pain rated 5 out of 10, and right arm numbness and tingling which are worse since her last visit. She has intermittent numbness and tingling down her right arm. She is doing physiotherapy and acupuncture 2 times a week with temporary relief. Her left knee pain is worse than her right knee pain. Bilateral knee range of motion is 0-130 degrees with discomfort and she has a positive McMurry's on the left knee. Cervical distraction elicits decrease tension in the shoulders positive bilateral. Shoulder decompression elicits severe pain in the cervical spine and bilateral upper trapezius is positive bilaterally. Finkelstein Test is positive on the right. The treatment plan is for a workstation reassessment and she will be placed on modified duty. Treatment requested is for Flurbiprofen 20%/Tramadol 20% in 180gm and Home interferential stimulator unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Home interferential stimulator unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy, Interferential Current Stimulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 114-121.

Decision rationale: Interferential current stimulation is a type of electrical stimulation treatment for pain. The literature has not shown benefit from this treatment, possibly because of the limited quality studies available. The MTUS Guidelines support the use of this treatment only when it is paired with other treatments that are separately supported and in workers who have uncontrolled pain due to medications that no longer provide benefit, medications are causing intolerable side effects, a history of substance abuse limits the treatment options, the pain does not respond to conservative measures, and/or pain after surgery limits the worker's ability to participate in an active exercise program. A successful one-month trial is demonstrated by decreased pain intensity, improved function, and a decreased use of medication. The submitted and reviewed documentation indicated the worker was experiencing pain in the neck with right arm numbness and tingling and pain in both knees. There was no suggestion of having failed treatment with medications, intolerable negative side effects, or any other related issues. There was no discussion describing special circumstances that sufficiently supported this request. In the absence of such evidence, the current request for a home interferential stimulator unit is not medically necessary.

Flurbiprofen 20%/Tramadol 20% in 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 rationale: The MTUS Guidelines strongly emphasize that any compound product that contains at least one drug or drug class that is not recommended is itself not recommended. The MTUS Guidelines recommend topical NSAIDs to treat pain due to osteoarthritis and tendonitis but not neuropathic pain. Use is restricted to several weeks because benefit decreases with time. It is specifically not recommended for use at the spine, hip, or shoulder areas. Diclofenac 1% is the medication and strength approved by the FDA. The Guidelines are silent as to the use of topical opioids, and the literature does not support their use. There was no discussion describing special circumstances that sufficiently supported this request. In the absence of such evidence, the current request for 180g of a compound containing flurbiprofen 20% Gabapentin and Tramadol 20% is not medically necessary.