

Case Number:	CM15-0036924		
Date Assigned:	03/05/2015	Date of Injury:	05/23/2014
Decision Date:	06/25/2015	UR Denial Date:	02/02/2015
Priority:	Standard	Application Received:	02/26/2015

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: New York
Certification(s)/Specialty: Pediatrics, Internal 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 64-year-old female, who sustained an industrial injury on May 23, 2014. The diagnoses have included cervical sprain/strain rule out Discopathy, lumbar spine anterolishesis at L4-L level and lumbar spine Discopathy at L4-L5 level. Treatment to date has included topical creams, oral medication and chiropractic care. Currently, the injured worker complains of cervical spine, lumbar spine and right shoulder pain. In a progress note dated November 19, 2014, the treating provider reports examination of the cervical spine revealed slight spasm over the cervical area, decreased range of motion, and positive orthopedic test on distraction test on the right, the shoulder examination revealed limited range of motion and orthopedic test showed positive on arm drop test positive on the right the lumbar spine revealed pain and spasm over the paraspinals radiating to the left leg, limited range of motion and orthopedic test revealed positive straight leg raise on the left.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar spine brace: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. 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 Support.

Decision rationale: According to ACOEM guidelines, lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. The ODG guidelines state that lumbar supports are recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific LBP (very low-quality evidence, but may be a conservative option). The IW has diagnoses of lumbar radiculopathy and lumbar anterolisthesis, which is a type of spondylolisthesis. The request is medically necessary and appropriate.

EMG/ NCS bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper 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) Neck Chapter.

Decision rationale: Per ODG guidelines EMG is recommended (needle, not surface) as an option in selected cases. While cervical electro diagnostic studies are not necessary to demonstrate a cervical radiculopathy, they have been suggested to confirm a brachial plexus abnormality or some problem other than a cervical radiculopathy, but these studies can result in unnecessary over treatment. Due to the concern for false positive EMG given the lack of neurologic findings, the EMG is not medically necessary and appropriate.

Acupuncture 2x6 right shoulder and lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204, Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder Chapter; ODG Acupuncture Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter & Shoulder Chapter.

Decision rationale: Per ODG guidelines acupuncture is not recommended for acute low back pain. Acupuncture is recommended as an option for chronic low back pain using a short course of treatment in conjunction with other interventions. There is no mention of physical interventions that are ongoing that would be done in conjunction with acupuncture. Per ODG guidelines acupuncture is recommended as an option for rotator cuff tendonitis, frozen shoulder, subacromial impingement syndrome, and rehab following surgery. There is no mention of these diagnoses in the documentation. This request is not medically necessary.

Compound Transdermal Cream: Gabapentin 10% Amitriptyline 10%-Bupivacaine 5% in 210 grams: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: Topical analgesics are indicated for treatment of osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment. They are recommended for short-term use. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Bupivaccine, amitripyline and gabapentin are not FDA approved for topical use. This request is not medically necessary and appropriate.

Flurbiprofen 20%-Baclofen 10% Dexamethasone 2% in 210 grams cream base: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: Topical analgesics are indicated for treatment of osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment. They are recommended for short-term use. Per MTUS guidelines, Baclofen is not recommended for topical use. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Dexamethasone and flurbiprofen is not FDA approved for topical use. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. This request is not medically necessary and appropriate.