

Case Number:	CM15-0062956		
Date Assigned:	04/08/2015	Date of Injury:	10/07/2007
Decision Date:	06/01/2015	UR Denial Date:	03/16/2015
Priority:	Standard	Application Received:	04/02/2015

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 56 year old female, who sustained an industrial/work injury on 10/7/07. The mechanism of injury was cumulative trauma. She reported initial complaints of neck, shoulder, back, and bilateral knee pain. The injured worker was diagnosed as having cervical disc disorder, lumbar disc disorder, bilateral shoulder derangement, and knee internal derangement. Treatment to date has included medication, diagnostics, and pain management consultation. MRI results were reported on 3/15/15 and 3/11/15. Currently, the injured worker complains of right cervical, lumbar, sacral, bilateral anterior and posterior shoulders, and bilateral anterior knee pain. Per the primary physician's progress report (PR-2) on 2/27/15, the examination of the upper extremities revealed limitations in active range of motion to bilateral shoulders, cervical and lumbar spine. Current plan of care included medication for pain control, therapy and consultations. The requested treatments include Cyclobenzaprine Hydrochloride, Tramadol, MRI Cervical Spine without contrast, MRI Lumbar Spine without contrast, 180gm FCL- Flurbiprofen 20%, Baclofen 2%, Dexamethasone 2%, Menthol 2%, Camphor 2%, Capsaicin 0.037%, Hyaluronic acid 0.20% compound cream, Physical therapy for the right hand & wrist, Referral to Rheumatologist, Referral to Orthopedic specialist, and 1 interferential stimulator home unit - initial trial for 60 days.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cyclobenzaprine Hydrochloride Tablets 7.5mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63-64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

Decision rationale: The California MTUS guidelines recommend muscle relaxants as a second line option for the short term treatment of acute low back pain, less than 3 weeks and there should be documentation of objective functional improvement. The clinical documentation submitted for review indicated that cyclobenzaprine was recommended for spasms. There were no spasms noted upon physical examination. The request would exceed the maximum guideline recommendations for 3 weeks of treatment with muscle relaxants. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for cyclobenzaprine hydrochloride tablets 7.5mg #60 is not medically necessary.

Tramadol 150mg #120: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 77-80 and 94.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain, ongoing management Page(s): 60, 78.

Decision rationale: The California MTUS guidelines recommend opiates for chronic pain. There should be documentation of an objective improvement in function, an objective decrease in pain, and evidence that the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review failed to provide documentation of objective functional improvement, an objective decrease in pain, and documentation the injured worker was being monitored for aberrant drug behavior and side effects. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for tramadol 150 mg #120 is not medically necessary.

MRI Cervical Spine without contrast: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

Decision rationale: The ACOEM Guidelines indicate for most patients with true neck or upper back problems, special studies are not needed unless there has been a 3 to 4 week period of conservative care and observation and the criteria for ordering imaging studies include the emergence of a red flag, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery, and the clarification of the anatomy prior to an invasive procedure. The clinical documentation submitted for review failed to provide documentation of specific conservative care directed at the treatment of the cervical spine. There was a lack of documentation of physiologic evidence of tissue insult or neurologic

dysfunction. Given the above, the request for MRI of the cervical spine without contrast is not medically necessary.

MRI Lumbar Spine without contrast: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: The ACOEM Guidelines indicate that for most patients, unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. The clinical documentation submitted for review failed to provide documentation of specific nerve compromise and there was a lack of documentation indicating the specific treatment for the lumbar spine. Given the above, the request for MRI of the lumbar spine is not medically necessary.

180gm FCL- Flurbiprofen 20%, Baclofen 2%, Dexamethasone 2%, Menthol 2%, Camphor 2%, Capsaicin 0.037%, Hyaluronic acid 0.20%: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Salicylate Topicals, Flurbiprofen, Capsaicin, Baclofen Page(s): 111, 105, 72, 25, 113. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: <http://www.drugs.com/search.php?searchterm=dexamethasone&a=1>
<http://www.drugs.com/search.php?searchterm=hyaluronic+acid>.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines indicates that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Regarding Topical Flurbiprofen - FDA approved routes of administration for Flurbiprofen include oral tablets and ophthalmologic solution. A search of the National Library of Medicine - National Institute of Health (NLM-NIH) database demonstrated no high quality human studies evaluating the safety and efficacy of this medication through dermal patches or topical administration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period. Salicylate Topicals are recommended. There is no peer-reviewed literature to support the use of topical baclofen. Per Drugs.com, "Dexamethasone is a corticosteroid that prevents the release of substances in the body that cause inflammation. Dexamethasone is used to treat many different inflammatory conditions such as allergic disorders, skin conditions, ulcerative colitis, arthritis, lupus, psoriasis, or breathing disorders." Capsaicin: Recommended only as an option in patients who have not responded or are intolerant to other treatments. Per drugs.com, "Hyaluronic acid is a natural substance found in all living organisms and provides volume and fullness to the skin." The clinical documentation submitted for review failed to indicate the injured worker had a trial and failure of antidepressants and anticonvulsants. There

was a lack of documentation of exceptional factors as multiple components are not recommended. There was a lack of documented rationale for the use of dexamethasone and hyaluronic acid. The request as submitted failed to indicate the frequency and body part to be treated. Given the above, the request for 180gm FCL-flurbiprofen 20%, baclofen 2%, dexamethasone 2%, menthol 2%, camphor 2%, capsaicin 0.037%, hyaluronic acid 0.20% is not medically necessary.

Physical therapy 2 times per week for 3 weeks for right hand & wrist for 6 visits: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98, 99.

Decision rationale: The California MTUS Guidelines recommend physical medicine treatment for myalgia and myositis for up to 10 visits. The clinical documentation submitted for review failed to provide documentation of prior conservative care that was provided. There was a lack of documentation of the quantity of sessions previously attended and the objective functional improvement. There was a lack of documentation of remaining functional deficits. Given the above, the request for physical therapy 2 times per week for 3 weeks for right hand & wrist for 6 visits is not medically necessary.

Referral to Rheumatologist: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Occupational Medicine Practice Guidelines, 2nd Edition, 2004 Page 127.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Introduction Page(s): 1.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines recommend upon ruling out a potentially serious condition, conservative management is provided. If the complaint persists, the physician needs to reconsider the diagnosis and decide whether a specialist evaluation is necessary. The clinical documentation submitted for review failed to provide the rationale for the requested rheumatology consultation. Given the above, the request for referral to rheumatologist is not medically necessary.

Referral to Orthopedic specialist: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Occupational Medicine Practice Guidelines, 2nd Edition, 2004 Page 127.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210-211.

Decision rationale: The ACOEM guidelines indicate a surgical consultation may be appropriate for injured workers who have a failure to increase range of motion and strength of musculature in the shoulder after exercise programs and who have clear clinical and imaging evidence of a

lesion that has been shown to benefit from surgical repair. The clinical documentation submitted for review indicated the injured worker was to have her shoulder reassessed. However, there was a lack of documentation indicating there was a failure of recent conservative care and documentation of imaging which included a lesion that has been shown to benefit from surgical repair. The request as submitted failed to indicate the specific physician specialist being requested. Given the above, the request for referral to orthopedic specialist is not medically necessary.

1 interferential stimulator home unit - initial trial for 60 days: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118.

Decision rationale: The California Medical Treatment & Utilization Schedule guidelines do not recommend interferential current stimulation (ICS) as an isolated intervention and should be used with recommended treatments including work, and exercise. The clinical documentation submitted for review failed to indicate the injured worker would utilize the unit as an adjunct to recommended treatments. The request as submitted failed to indicate whether the unit was for rental or purchase. There was a lack of documentation of exceptional factors to warrant non-adherence to guideline recommendations. Given the above, the request for 1 interferential stimulator home unit - initial trial for 60 days is not medically necessary.