MAXIMUS Federal Services

Case Number:	CM15-0070337		
Date Assigned:	04/17/2015	Date of Injury:	12/06/2014
Decision Date:	07/22/2015	UR Denial Date:	03/26/2015
Priority:	Standard	Application Received:	04/13/2015

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: 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 50 year old male, who sustained an industrial injury on 12/6/14. The injured worker has complaints of back and right shoulder pain. The diagnoses have included thoracic sprain/strain; lumbar sprain/strain and cervical sprain/strain. Treatment to date has included rifampin; ibuprofen; Tylenol; braces lumbar spine; collar/rib belt and physical therapy. The request was for magnetic resonance imaging (MRI) of thoracic spine; flurbiprofen 2%/baclofen 5%/dexamethasone 0.2%/ menthol 2%/camphor 2%.capsaicin 0.025%/hyaluronic acid 0.2% n cream base 240grams; physical therapy 2 times for the thoracic area; physical therapy right shoulder 2 times 4; psyche consultation and dextromethorphan 10%/gabapentin 10%; bupivacaine 5%/camphor 2%/menthol 2%/hyaluronic acid 0.2% in cream base.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI OF THORACIC SPINE: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, MRIs.

Decision rationale: As per MTUS/ACOEM Imaging studies are recommended when there are unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computer tomography [CT] for bony structures). ODG States that MRIs are recommended for uncomplicated back pain when symptoms of radiculopathy persist for at least one month after conservative therapy. Review of submitted medical records of injured worker are not clear about any subjective or objective findings that identify specific nerve compromise. Also in the documentation available for review there is no information about what will be the medical decision-making based upon the outcome of the request. Without such evidence and based on guidelines cited, the request for MRI OF THORACIC SPINE is not medically necessary and appropriate

FLURBIPROFEN 20%/ BACLOFEN 5%/ DEXAMETHASONE 0.2%/ MENTHOL 2%/ CAMPHOR 2%/ CAPSAICIN 0.025%/ HYALURONIC ACID 0.2%/ IN CREAM BASE 240G: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL.

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

Decision rationale: According to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, muscle relaxants, local anesthetics or antidepressants. Guidelines indicate that any compounded product that contains at least one non-recommended drug (or drug class) is not recommended for use. In this injured worker the Medical necessity for the requested topical compound cream has not been established. There is no documentation in the submitted Medical Records that the injured worker has failed a trial of antidepressants and anticonvulsants. Therefore, as per guidelines stated above, the requested topical compound cream is not medically necessary.

PHYSICAL THERAPY 2X4 FOR THE THORACIC AREA: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL MEDICINE.

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

Decision rationale: The prescription for Physical Therapy is evaluated in light of the MTUS recommendations for Physical Therapy MTUS recommends 1) Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. 2) Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. The records are not clear about the functional benefit, the injured worker had from prior physical therapy visits. Also there is no mention of any significant change of symptoms or clinical findings, or acute flare up to support PT. The request for physical therapy for thoracic area is not medically necessary and appropriate.

PHYSICAL THERAPY RIGHT SHOULDER 2X4: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL MEDICINE Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 210, Chronic Pain Treatment Guidelines Physical Therapy Page(s): 98-99.

Decision rationale: The prescription for Physical Therapy is evaluated in light of the MTUS recommendations for Physical Therapy MTUS recommends 1) Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. 2) Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment

process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. The records are not clear about the functional benefit, the injured worker had from prior physical therapy visits. Also there is no mention of any significant change of symptoms or clinical findings, or acute flare up to support PT. The request for physical therapy for right shoulder is not medically necessary and appropriate.

PSYCHE CONSULTATION: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM CHAPTER 7 PAGE 127.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Psychological Treatment Page(s): 101.

Decision rationale: MTUS recommends Psychological treatment for appropriately identified patients during treatment for chronic pain. Psychological intervention for chronic pain includes setting goals, determining appropriateness of treatment, conceptualizing a patient's pain beliefs and coping styles, assessing psychological and cognitive function, and addressing co-morbid mood disorders (such as depression, anxiety, panic disorder, and post-traumatic stress disorder). Cognitive behavioral therapy and self-regulatory treatments have been found to be particularly effective. Medical records of injured worker do not give any information about the complaints or exam findings that will make it necessary for the requested treatment. Given limited information, the request is not medically necessary.

DEXTROMETHORPHAN 10%/ GABAPENTIN 10%/ BUPIVACAINE 5%/ CAMPHOR 2%/ MENTHOL 2%/ HYALURONIC ACID 0.2% IN CREAM BASE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL.

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

Decision rationale: According to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of anti-depressants and anti-convulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, muscle relaxants, local anesthetics or antidepressants. Guidelines indicate that any compounded product that contains at least one non-recommended drug (or drug class) is not recommended for use. In this injured worker the Medical necessity for the requested topical compound cream has not been established. There is no documentation in the submitted Medical Records that the injured worker has failed a trial of anti-depressants and anti-convulsants. Therefore, as per guidelines stated above, the requested topical compound cream is not medically necessary.