MAXIMUS Federal Services

Case Number:	CM15-0071103		
Date Assigned:	04/21/2015	Date of Injury:	12/30/2009
Decision Date:	07/09/2015	UR Denial Date:	03/16/2015
Priority:	Standard	Application Received:	04/14/2015

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: North Carolina, Georgia
Certification(s)/Specialty: Family Practice

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 male, who sustained an industrial injury on 12/30/2009. According to a pain management consultation report dated 03/06/2015, the injured worker complained of left lumbar, left sacroiliac lumbar, right lumbar, right sacroiliac, sacral, right anterior wrist, left anterior wrist, left posterior wrist, right posterior wrist, left anterior shoulder, left anterior arm, left posterior shoulder, left posterior arm, right anterior leg, right anterior knee, right shin, right ankle, right foot, right buttock, right posterior leg, right posterior knee, right calf, right ankle and right foot pain. Pain was rated 6 on a scale of 1-10. He reported numbness and tingling, dizziness, anxiety and stress. Diagnoses included carpal tunnel syndrome wrist (median nerve) left wrist status post carpal tunnel release, cervical intervertebral disc disorder with myelopathy, lumbar intervertebral disc disorder with myelopathy and rotator cuff shoulder. Treatments have included physiotherapy and medications. Currently under review is the request for Norco, physiotherapy for the cervical and lumbar regions, MRI for the cervical and lumbar spine, right and left wrist and left shoulder, an interferential stimulator for ninety days, and a topical compound cream.

IMR ISSUES, DECISIONS AND RATIONALES

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

Norco 10/325 mg, sixty count: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78 - 80, 91, and 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section 2 Page(s): 74-89.

Decision rationale: CA MTUS allows for the use of opioid medication, such as Norco, for the management of chronic pain and outlines clearly the documentation that would support the need for ongoing use of an opioid. These steps include documenting pain and functional improvement using validated measures at 6 months intervals, documenting the presence or absence of any adverse effects, documenting the efficacy of any other treatments and of any other medications used in pain treatment. The medical record in this case does not use any validated method of recording the response of pain to the opioid medication or of documenting any functional improvement. It does not address the efficacy of concomitant medication therapy. Therefore, the record does not support medical necessity of ongoing opioid therapy with Norco.

Physiotherapy for the cervical and lumbar regions, twice weekly for three weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section 2 Page(s): 98-99.

Decision rationale: The CA MTUS recommends physical therapy for management of chronic pain with a clear preference for active therapy over passive therapy. Physical therapy includes supervision by therapist then the patient is expected to continue active therapies at home in order to maintain improvement levels. Guidelines direct fading treatment frequency from 3 times a week to one or less with guidelines ranging depending on the indication: Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks, Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2), 8-10 visits over 4 weeks, Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks. In this case, the claimant has completed prior physical therapy and the medical records do not contain any information that would support any additional expected benefit from additional physical therapy. The request for physiotherapy 2 x 3 weeks is denied. Therefore, the requested treatment is not medically necessary.

MRI for the cervical and lumbar spine, bilateral wrist, and left shoudler: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints, Chapter 12 Low Back Complaints Page(s): 182,

214, 272 and 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm Hand, Wrist, MRI.

Decision rationale: ACOEM chapter on back complaints describes that MRI is indicated when there are unequivocal objective findings of specific nerve compromise in a person with symptoms who do not respond to treatment and for whom surgery would be a reasonable intervention. The medical record contains no documentation of unequivocal nerve compromise and MRI lumbar spine is not medically indicated. ACOEM chapter on neck complaints describes that MRI is indicated when there are unequivocal objective findings of specific nerve compromise in a person with symptoms who do not respond to treatment and for whom surgery would be a reasonable intervention. The medical record does not include any such physical examination findings and no surgical intervention is proposed in the records. Cervical MRI is not medically indicated. ACOEM chapter on shoulder complaints describes that MRI is recommended for pre-operative evaluation of partial or full thickness rotator cuff tears. MRI is not recommended for routine investigation of the shoulder joint for evaluation without surgical indication. The submitted medical records do not describe a concern for rotator cuff tear and do not indicate any plan for surgical intervention. As such, shoulder MRI is not medically indicated. CA MTUS does not address the indications for MRI of the wrist. ODG section on Forearm, Wrist and Hand outlines the indications for MRI of the wrist which include (1) acute hand or wrist trauma, suspect acute distal radius fracture, radiographs normal, next procedure if immediate confirmation or exclusion of fracture is required (2) Acute hand or wrist trauma, suspect acute scaphoid fracture, radiographs normal, next procedure if immediate confirmation or exclusion of fracture is required (3) Acute hand or wrist trauma, suspect gamekeeper injury (thumb MCP ulnar collateral ligament injury) (4) Chronic wrist pain, plain films normal, suspect soft tissue tumor (5) Chronic wrist pain, plain film normal or equivocal, suspect Kienbck's disease (6) Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. In this case, the complaint is a chronic complaint with no acute component. There is no documentation of plain films. The suspected condition is carpal tunnel syndrome for which MRI is not a recommended imaging modality. MRI of wrist is not indicated. Therefore, the requested treatment is not medically necessary.

Interferential stimulator for ninety days: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section 2 Page(s): 118-120.

Decision rationale: CA MTUS does not recommend the use of an Inferential Current Stimulation (ICS) as an isolated intervention. There is limited evidence for its effectiveness when combined with other interventions such as return to work, exercise and medications. Trials have been performed on neck, shoulder, jaw, knee and low back pain. ICS may be possibly appropriate for the following conditions: (1) Pain is ineffectively controlled due to diminished effectiveness of medications; or (2) Pain is ineffectively controlled with medications due to side effects; or (3) History of substance abuse; or- Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or (4)

Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). If those criteria are met, then a one month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction. In this case there is no documentation of a one month trial of ICS and 90 day Inferential Stimulator is not medically necessary.

FCL: Flurbiprofen 20%/Baclofen 2%/Dexamethasone 2%/Menthol 2%/ Camphor 2%/Capsaicin 0.0375%/Hyaluronic Acid 0.2%, 180 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 Section 2 Page(s): 111-113.

Decision rationale: CA MTUS recommends limited use of topical analgesics. These are primarily recommended for neuropathic pain with antidepressants and antiepileptics have failed. CA MTUS specifically prohibits the use of combination topical analgesics in which any component of the topical preparation is not recommended. Muscle relaxants in topical formulation are explicitly not approved in the CA MTUS. Menthol is not recommended as a topical agent. As such, the request for flurbiprofen/baclofen/dexamethasone/menthol/camphor/ capsaicin/hyaluronic acid is not medically necessary and the original UR decision is upheld Therefore, the requested treatment is not medically necessary.