MAXIMUS Federal Services

Case Number:	CM13-0027940		
Date Assigned:	03/14/2014	Date of Injury:	10/02/2007
Decision Date:	04/23/2014	UR Denial Date:	09/09/2013
Priority:	Standard	Application Received:	09/23/2013

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. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is an employee of [redacted] and has submitted a claim for reflex sympathetic dystrophy associated with an industrial injury date of October 2, 2007. A utilization review from September 9, 2013 denied the requests for aquatic therapy due to no clear evidence to support aquatic physical therapy instead of land-based therapy, left lumbar sympathetic block due to unclear treatment plan, H wave unit due to no clear evidence of failure of recommended prior treatment, Protonix due to the patient not meeting guideline recommendations for GI prophylaxis, Cyclobenzaprine due to the chronicity of the problem, Medrol due to no evidence to support systemic corticoids in chronic pain, Flexeril due to chronicity of the problem and duplicity, and Voltaren gel. Reasons for denial of Voltaren gel were not made available. Treatment to date has included opioid and non-opioid pain medications, home exercise program, and lumbar sympathetic ganglion block. Medical records from 2013 were reviewed showing the patient complaining of left foot pain described as burning. The patient received the lumbar sympathetic ganglion block in November 2013 however no progress notes were available after this date to indicate the outcome of this procedure. The physical exam demonstrated moderate generalized ankle edema of the left ankle and foot. There was also severe left foot/ankle tenderness. The left foot/ankle also had allodynia to touch and pressure diffusely. Range of motion for the left foot/ankle was limited.

IMR ISSUES, DECISIONS AND RATIONALES

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

AQUATIC PT 3X4: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22-23.

Decision rationale: The Expert Reviewer's decision rationale: As stated on pages 22-23 of the California MTUS Chronic Pain Medical Treatment Guidelines, aquatic therapy is recommended as an alternative to land-based physical therapy where reduced weight-bearing is desirable such as extreme obesity or fractures of the lower extremity. In this case, the patient has reflex sympathetic dystrophy of the left foot and ankle. However, there was no discussion concerning the patient's ability to function with regards to the left foot. There was no indication that the patient could not walk properly or weight-bear on the left foot. It is unclear whether the patient was also extremely obese. The specific body part to be treated for the aquatic therapy was also not specified in the request. It remains unclear why land-based PT would be insufficient. Therefore, the request for aquatic therapy is not medically necessary.

LEFT LUMBAR SYMPATHETIC BLOCK: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 39.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 103-104.

Decision rationale: The Expert Reviewer's decision rationale: As stated on pages 103-104 of the California MTUS Chronic Pain Medical Treatment Guidelines, regional sympathetic blocks, which include lumbar sympathetic blocks, are recommended for diagnostic and therapeutic procedures for CRPS. Lumbar sympathetic blocks have limited evidence to support this procedure. Adequacy of the block may be generally measured via skin temperature of the affected appendage. This procedure should also be accompanied by progressive physical therapy to optimize success. In this case, the patient has CRPS of the left lower extremity. The patient was prescribed a lumbar sympathetic block for this diagnosis and received the procedure in November 2013. However, the outcome of this procedure was not documented. It is also unclear whether the patient had concurrent physical therapy after this procedure. Therefore, the request for left lumbar sympathetic block is not medically necessary.

H WAVE UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117-118.

Decision rationale: As stated on pages 117-118 of the California MTUS Chronic Pain Medical Treatment Guidelines, H-wave stimulation is not recommended as an isolated intervention, but a one-month trial may be considered if used as an adjunct to a program of evidence-based functional restoration. There should be a failure of conventional therapy, including physical therapy, medications, and TENS unit prior to consideration of a trial. In this case, the prescription of this unit was not accompanied by documentation concerning failure of conservative treatment such as physical therapy, medications, and prior use of a TENS unit. The treatment plan for this prescription is also unclear. The request does not specify treatment duration. Therefore, the request for H wave unit is not medically necessary.

PROTONIX: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

Decision rationale: As stated on page 68 of the California MTUS Chronic Pain Medical Treatment Guidelines, proton pump inhibitors are recommended for patients who are at high risk for gastrointestinal events. In this case, it is unclear whether the patient has been prescribed this medication in the past given a 2007 injury date. There is no discussion concerning the patient's risk for neither gastrointestinal events nor other complaints. The request also does not specify frequency, duration, and dosage. Therefore, the request for Protonix is not medically necessary.

CYCLOBENZAPRINE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 41-42.

Decision rationale: As stated on pages 41-42 of the California MTUS Chronic Pain Medical Treatment Guidelines, cyclobenzaprine is recommended as an option as a short course therapy for management of back pain. In this case, it is unclear whether the patient has had prior prescriptions of this medication given a 2007 injury date. Recent progress notes have focused on a foot problem rather than a back problem. The request does not specify frequency, dosage, and duration. Specific assessment of ongoing therapeutic benefit was not identified. Therefore, the request for cyclobenzaprine is not medically necessary

MEDROL DOSEPAK 4MG TABS #1 PACK: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 37.

Decision rationale: As stated on page 37 of the California MTUS Chronic Pain Medical Treatment Guidelines, corticosteroids are commonly used drugs for CRPS regional inflammatory reaction as a limited course. In this case, there is no treatment plan, indication, or discussion concerning this prescription. It is unclear whether the patient has had this medication in the past with a 2007 date of injury. Therefore, the request for Medrol dosepak is not medically necessary.

FLEXERIL 5MG #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 41-42.

Decision rationale: As stated on pages 41-42 of the California MTUS Chronic Pain Medical Treatment Guidelines, cyclobenzaprine is recommended as an option as a short course therapy for management of back pain. In this case, it is unclear whether the patient has had prior prescriptions of this medication given a 2007 injury date. Recent progress notes have focused on a foot problem rather than a back problem. There is also a concurrent request for cyclobenzaprine; Flexeril is a brand name of cyclobenzaprine. This is a duplicate request. Specific assessment of ongoing therapeutic benefit was not identified. Therefore, the request for cyclobenzaprine is not medically necessary.

VOLTAREN XR GEL 1%: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112.

Decision rationale: As stated on page 112 of the California MTUS Chronic Pain Medical Treatment Guidelines, Voltaren gel is indicated for relief of osteoarthritis pain in joints to lend themselves to topical treatment such as ankles, elbows, feet, hands, knees, and wrists. In this case, it is unclear to whether the patient has had this prescription in the past especially with a 2007 date of injury. There is also no discussion concerning osteoarthritis in this patient. There is no indicated frequency or application site for this request. Therefore, the request for Voltaren gel is not medically necessary.