MAXIMUS Federal Services

Case Number:	CM13-0065210		
Date Assigned:	01/03/2014	Date of Injury:	10/09/2013
Decision Date:	06/04/2014	UR Denial Date:	12/03/2013
Priority:	Standard	Application Received:	12/12/2013

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 lumbar sprain, sprain of the hip and thigh, contusion of the chest wall, and closed fracture of the rib associated with an industrial injury date of 10/09/2013. The treatment to date has included physical therapy for one (1) visit, and medications such as Norco, cyclobenzaprine, tramadol, pantoprazole, topical analgesics, and naprosyn. The medical records from 2013 were reviewed, showing that the patient complained of constant pain at the right side of chest, ribcage, and low back, which was graded 8/10 in severity. The pain was aggravated by coughing, deep breathing, rotation, reaching overhead, carrying, pushing, pulling, prolonged standing and walking. The patient did not complain of right hip pain as of lastest progress report dated November 2013. The physical examination showed tenderness over the intercostal region and lumbar spine. A muscle spasm was noted at the right hip and paralumbar region. The range of motion of the lumbosacral spine and right hip was restricted on all planes. Muscle strength was graded 5/5. The deep tendon reflexes were equal and symmetric. An x-ray of right ribs, dated 10/09/2013, documented no abnormality. A repeat x-ray, dated 10/10/2013, revealed no definite acute fracture or destructive process. A utilization review from 12/03/2013 denied the requests for an MRI of the right hip due to the lack of initial plain films request and/or result; an initial functional capacity evaluation (FCE) of the right hip, because of lack of documentation of failure of return to work; physical therapy times two (2) additional visits, to make a total of eight (8) initial visits, for the right hip, because there was no evidence that the patient responded to the previous therapy sessions; flurbiprofen 20%/tramadol 10% in Mediderm base and gabapentin 10%/tramadol 20%/lidocaine 5% in Mediderm base, because topical analgesics are largely experimental. On the other hand, the request for acupuncture two (2) times a week for four (4) weeks for the right hip was modified into six (6) sessions since the initial trial of acupuncture should only be six (6) sessions

as stated in the guidelines. Likewise, the request for urine toxicology/urine drug screen monitoring to continue while medications are prescribed no less than frequently was modified into two (2) times a year, because there was no documented risk factors to necessitate frequent monitoring.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI RIGHT HIP: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES, HIP AND PELVIS CHAPTER, MRI (MAGNETIC RESONANCE IMAGING) SECTION.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), HIP AND PELVIS SECTION, MAGNETIC RESONANCE IMAGING (MRI).

Decision rationale: The Official Disability Guidelines indicate that an MRI is both highly sensitive and specific for the detection of many abnormalities, involving the hip or surrounding soft tissues and should in general be the first imaging technique employed following plain films. In this case, the patient experienced right hip pain during the industrial accident. However, the most recent progress report, dated 10/15/2013, cited the absence of hip pain, although there were objective findings of muscle spasm and limitation of motion noted at the right hip. There is no evidence that a plain film was previously performed, as recommended by the guidelines stated above. There is no discussion why an MRI should be executed as an initial diagnostic procedure instead of an x-ray. Therefore, the request for an MRI of right hip is not medically necessary.

INITIAL FCE OF THE RIGHT HIP: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES, FITNESS FOR DUTY CHAPTER, FUNCTIONAL CAPACITY EVALUATION (FCE) CHAPTER GUIDELINES FOR PERFORMING AN FCE and the ACOEM PRACTICE GUIDELINES, 2ND EDITION, INDPENDENDENT MEDICAL EXAMINATIONS AND CONSULTATIONS CHAPTER.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: AMERICAN COLLEGE OF OCCUPATION AND ENVIRONMENTAL MEDICINE (ACOEM) 2ND EDITION, CHAPTER 7, 132-139.

Decision rationale: The ACOEM Guidelines indicate that functional capacity evaluations (FCEs) may be ordered by the treating physician if the physician feels the information from such testing is crucial. FCEs may establish physical abilities and facilitate the return to work. However, FCEs can be deliberately simplified evaluations based on multiple assumptions and subjective factors, which are not always apparent to the requesting physician. There is little

scientific evidence confirming that FCEs predict an individual's actual capacity to perform in the workplace. In this case, the rationale given for an FCE is because it is recommended by the AMA Physicians Guide and ACOEM. There is no further discussion regarding the indication for an FCE and whether this will be crucial to the management of the patient. It is noted that the patient was considered with a status of temporary total disability until 12/13/2013. However, there is no evidence of prior unsuccessful return to work trials that might make a case for functional capacity evaluation testing. Therefore, the request for initial FCE of right hip is not medically necessary.

PHYSICAL THERAPY 2X4 WEEKS FOR THE RIGHT HIP: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL MEDICINE. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), HIP CHAPTER, PHYSICAL MEDICINE AND TREATMENT.

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

Decision rationale: The Chronic Pain Guidelines indicate that physical medicine is recommended and that the given frequency should be tapered and transition into a self-directed home program. In this case, the rationale given for physical therapy is to emphasize a strong rehabilitative therapeutic exercise regimen to prevent further deconditioning. The patient was initially given physical therapy for three (3) visits in a week. A physical therapy note, dated 10/16/2013, cited that the patient was given electrical stimulation and massage; however, the patient was unable to perform the exercises due to severe pain. It is unclear if the patient completed the total number of visits. The medical records submitted and reviewed do not indicate relief of pain or functional gains derived from the previous therapy sessions. Therefore, the request for physical therapy two (2) times a week for four (4) weeks for the right hip is not medically necessary.

ACCUPUNTURE 2 X 4 WEEK FOR THE RIGHT HIP: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), INTEGRATED TREATMENT/DISABILITY DURATION GUIDELINES, HIP & PELVIS CHAPTER and the ODG ACUPUNCTURE GUIDELINES.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The Acupuncture Medical Treatment Guidelines indicate that acupuncture is used as an option when pain medication is reduced or not tolerated, it may be used in addition to physical rehabilitation and/or surgical intervention to hasten functional recovery. The frequency and duration to produce functional improvement is three to six (3-6) treatments, frequency of one to three (1-3) times per week, and a duration of one to two (1-2) months. The rationale given for this request is to diminish pain and to reduce the need for non-steroidal anti-inflammatory drug (NSAID) and opiate medications. However, the present request exceeds the

recommended initial acupuncture visit of three to six (3-6) treatment sessions. Therefore, the request for acupuncture two (2) times a week for four (4) weeks for the right hip is not medically necessary.

FLURBIPROFEN 20% TRAMADOL 10% IN MEDIDERN BASE: Upheld

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

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

Decision rationale: The Chronic Pain Guidelines indicate that any compounded product that contains at least one (1) drug (or drug class) that is not recommended is not recommended. Topical analgesics are largely experimental in use with few randomized controlled trials to determine safety or efficacy. The formulation for topical non-steroidal anti-inflammatory drugs (NSAIDs) are only supported for diclofenac in the guidelines. The guidelines do not support flurbiprofen as a topical NSAID. Tramadol is indicated for moderate to severe pain, but is likewise not recommended for topical use. There is no other discussion in the documentation concerning the need for use of unsupported topical analgesics. Therefore, the request for flurbiprofen 20%/tramadol 10% in Mediderm base is not medically necessary.

GABAPENTIN 10%/ AMITRIPTYLINE 10%/ DEXAMETHORPHAN 10% IN MEDIDERN BASE: Upheld

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

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

Decision rationale: The Chronic Pain Guidelines indicate that any compounded product that contains at least one (1) drug (or drug class) that is not recommended is not recommended. Many agents are in combination for pain control such as antidepressants (amitriptyline), opioids, glutamate receptor antagonists. Topical analgesics are largely experimental in use with few randomized controlled trials to determine safety or efficacy. Gabapentin is an anti-epilepsy drug considered as a first-line treatment for neuropathic pain in oral formulation. Dextromethorphan is not addressed in the guidelines. There is no discussion in the documentation concerning the need for use of unsupported topical analgesics. Therefore, the request for Gabapentin 10%/Amitriptyline 10%/Dexamethorphan 10% in Mediderm base is not medically necessary.

GABAPENTIN 10% / TRAMADOL 20% / LIDOCAINE 5% IN MEDIDERN BASE: Upheld

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

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

Decision rationale: The Chronic Pain Guidelines indicate that topical analgesics are largely experimental in use with few randomized controlled trials to determine safety or efficacy. Topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants). Gabapentin is an anti-epilepsy drug considered as a first-line treatment for neuropathic pain in oral formulation. Tramadol is indicated for moderate to severe pain, but is likewise not recommended for topical use. Any compounded product that contains at least one (1) drug (or drug class) that is not recommended is not recommended. There is no discussion in the documentation concerning the need for use of unsupported topical analgesics. Therefore, the request for Gabapentin 10% /Tramadol 20% /Lidocaine 5% in Mediderm base is not medically necessary.

URINE TOXICOLOGY/URINE DRUG SCREEN MONITORING TO CONTINUE WHILE MEDICATIONS ARE BEING PRESCRIBED, NO LESS FREGUENTLY THAN MONTHLY: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines DRUG TESTING AND CRITERIA FOR USE OF OPIOIDS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), PAIN CHAPTER, URINE DRUG TESTING (UDT).

MAXIMUS guideline: Decision based on MTUS ACOEM,Chronic Pain Treatment Guidelines OPIOIDS CHAPTER, URINE DRUG SCREENING.

Decision rationale: The ACOEM Guidelines indicate that the routine use of urine drug screening for patients on chronic opioids is recommended as there is evidence that it can identify aberrant opioid use. It is indicated for all patients on chronic opioid use for chronic pain. Screening is recommended randomly at least twice and up to four (4) times a year. The guidelines also indicate that the screening should also be performed "for cause", such as the provider's suspicion of substance misuse. In this case, patient has been prescribed with Norco, cyclobenzaprine, Naprosyn and tramadol since October 2013. A urine drug screen was performed on 11/15/2013; however, the results were not disclosed. There is no discussion of aberrant drug behavior that requires frequent testing. Therefore, the request for urine toxicology/urine drug screen monitoring to continue while medications are being prescribed, no less frequenty than monthly is not medically necessary.