

Case Number:	CM14-0103767		
Date Assigned:	07/30/2014	Date of Injury:	05/29/2014
Decision Date:	12/26/2014	UR Denial Date:	06/27/2014
Priority:	Standard	Application Received:	07/03/2014

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 applicant is a represented [REDACTED] employee who has filed a claim for chronic mid and low back pain reportedly associated with an industrial injury of May 29, 2014. In a Utilization Review Report dated June 25, 2014, the claims administrator denied a physical performance evaluation/functional capacity evaluation, invoking non-MTUS Chapter 7 ACOEM Guidelines; denied a request for an interferential unit, invoking a variety of MTUS and non-MTUS guidelines; and denied topical compounded medications. Despite the fact that this does not appear to be a chronic pain case, the MTUS Chronic Pain Medical Treatment Guidelines were invoked in several circumstances. The applicant's attorney subsequently appealed. The functional capacity evaluation in question was performed on July 30, 2014. The applicant was not working, it was acknowledged. The applicant self-limited several tasks and tests, it was noted. In a progress note dated July 14, 2014, the applicant was placed off of work, on total temporary disability, owing to ongoing complaints of 6-10/10 low back pain. Twelve sessions of physical therapy, a Flurbiprofen-Tramadol containing compound, and an Amitriptyline-Dextromethorphan-Gabapentin containing compound were endorsed, along with localized intense neurostimulation therapy (LINT).

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Performance - FCE: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints,Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation ACOEM: Chapter 7- Independent Medical Examinations and Consultations: Page: 138

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation Page(s): 21.

Decision rationale: While the MTUS Guidelines in ACOEM Chapter 2, page 21 does acknowledge that a functional capacity evaluation can be employed when necessary to translate medical impairment into limitations and restrictions, in this case, however, it was not clearly stated why it was necessary to formally quantify the applicant's physical abilities and capabilities via the functional capacity evaluation (FCE) issue. The applicant was off of work, on total temporary disability. It was not clear why FCE testing was being performed as it was not clear if (a) the applicant has a job to return to and/or (b) the applicant was intent on returning to the workplace and/or workforce. The FCE testing in question did not appear to appreciably alter the treatment plan as the applicant remained off of work, on total temporary disability (TTD), despite having undergone the FCE at issue. The attending provider's progress note did not incorporate any compelling applicant-specific rationale which would have augmented the tepid ACOEM position on functional capacity evaluations (FCEs). Therefore, the request was not medically necessary.

IF (interferential) unit, Hot/ Cold unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints,Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Work Loss Data Institute LLC; Corpus Christi, TXSection Low Back- Lumbar & Thoracic (Acute & Chronic

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300; 12-8, page 308.

Decision rationale: The primary pain generator is the low back. While the MTUS Guideline in ACOEM Chapter 12, Table 12-8, page 308 does acknowledge that at-home applications of local heat or cold to the low back are "optional" in the management of low back pain complaints, as were/are present here, by implication, ACOEM does not support more elaborate, high-tech devices for delivery of hot and cold therapy as was being sought here. Similarly, the MTUS Guidelines in ACOEM Chapter 12, page 300 notes that insufficient evidence exists to determine the effectiveness of symptomatic therapy, non-invasive electrical stimulation modality often known as interferential therapy. Thus, the ACOEM position on both interferential therapy and elaborate devices to deliver hot and cold therapy is, at best, tepid-to-unfavorable. The attending provider's progress note did not incorporate any compelling applicant-specific rationale which would augment and/or offset the tepid-to-unfavorable ACOEM position on the articles at issue. Therefore, the request is not medically necessary.

Gabapentin 10%, AMytriptyline 10%, Dextromethorphan 10% 240 GM: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): Table 3-1,49.

Decision rationale: As noted in the MTUS-adopted ACOEM Guidelines in Chapter 3, Table 3-1, page 49, topical medications such as the gabapentin-containing compound at issue are deemed "not recommended." In this case, there was no evidence of intolerance to and/or failure of multiple classes of first-line oral pharmaceuticals so as to justify selection, introduction, and/or ongoing usage of a gabapentin-containing topical compound at issue. Therefore, the request was not medically necessary.

Flubiprofen 20%, Tramadol 20% 240 GM.: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): Table 3-1,49.

Decision rationale: As noted in the MTUS-adopted ACOEM Guidelines in Chapter 3, Table 3-1, page 49, topical medications such as the flurbiprofen-containing compound at issue, as a class, are deemed "not recommended." In this case, there was no evidence of intolerance to and/or failure of multiple classes of first-line oral pharmaceuticals so as to justify selection, introduction, and/or ongoing usage of the flurbiprofen-containing compound at issue. Therefore, the request was not medically necessary.