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| Case Number: | CM14-0115098 | | |
| Date Assigned: | 08/04/2014 | Date of Injury: | 05/16/2007 |
| Decision Date: | 09/11/2014 | UR Denial Date: | 07/15/2014 |
| Priority: | Standard | Application Received: | 07/22/2014 |

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 Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine, and is licensed to practice in Texas & Oklahoma. 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 injured worker is a 52-year-old female who reported an injury on 05/16/2007. The mechanism of injury reportedly occurred when she was walking backwards avoiding a fall on a student losing balance and fell forward landing on bilateral knees and hands. Current diagnoses include lumbar degenerative disc disease, lumbar herniated nucleus pulposus, low back pain, lumbar radiculopathy, lumbar sprain, lumbar stenosis, sciatica, status post hemilaminectomy, and a history of gastritis. Past treatments included medications, diagnostic studies, aquatic therapy, and physical therapy. Diagnostic studies included x-rays, MRIs, and NCV/EMG. Surgical history included status post hemilaminectomy, foraminotomy and decompression at L4-5 and L5-S1 on 06/26/2013. On 06/24/2014, the injured worker complained of severe pain in the neck and moderate to severe pain in the low back. She rated the pain of her neck a 9/10 and her low back an 8/10. She stated the pain in her neck traveled through her arms to her hands with associated numbness and tingling. She reported the pain in her back traveled through her legs with associated numbness and tingling. Upon examination of the cervical spine, there was tenderness to palpation, limited range of motion, and myospasms. Sensory defects in the right C6 and bilateral C7 were noted. In the lumbar spine, there was tenderness to palpation, limited range of motion, and myospasms. On examination of bilateral knees, there was decreased range of motion with pain at the extremities of all ranges. There was tenderness to palpation and myospasms. The treatment plan was to request an NCV/EMG of the bilateral upper extremities to verify radicular complaints, to authorize aquatic physical therapy twice a week for 4 weeks to improve range of motion, reduce pain, and for spasms. She is to continue her meds and follow-up in 4 weeks. There is a handwritten note for 07/03/2014 that is hard to decipher. On 07/03/2014, the injured worker was seen for back pain that was a 9/10, bilateral knee pain that was a 7/10 with numbness bilateral arms and legs, and bilateral wrist sprain. The injured worker had sleep disturbance secondary to pain. Upon exam, there was limited range of motion and tenderness to bilateral knees. There was a positive McMurray's test bilaterally. The treatment plan is for chiropractic care 3 times a week, UA test for toxicology, Functional Capacity Evaluation, referral for neurologist consult, motorized cold therapy, naproxen 550 mg, tramadol ER 150 mg, omeprazole 20 mg, cyclobenzaprine 7.5 mg, topical compound creams, and medical foods. The request is for chiropractic therapy 3 times a week for 4 weeks, toxicology-urine drug screen, interferential unit rental or

purchase not specified, motorized cold therapy unit rental or purchase not specified, physiotherapy Functional Capacity Evaluation, topical flurbiprofen/capsaicin/camphor 10%, 0.025%, 2%, 1% 120 gm, topical ketoprofen/cyclobenzaprine/lidocaine 10%, 3%, 5% 120 gm, Prilosec-omeprazole 20 mg #60, Flexeril- cyclobenzaprine 7.5 mg #60, Theramine #90 two bottles, Sentra PM #60 one bottle, Sentra AM #60 one bottle, MRI of the bilateral knees, and consultation with a neurologist. The rationales were not provided. The Request for Authorization was dated 07/03/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic Therapy 3 times a week for 4 weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58.

Decision rationale: The injured worker has a history of back pain and knee pain. The CA MTUS guidelines recommend manual therapy for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. The request is for 12 visits. The Guidelines recommend 6 visits with evidence of objective functional improvement. The request is in excess of the Guidelines recommendations. There is a lack of documentation as to the body part specified. As such, the request for Chiropractic Therapy 3 times a week for 4 weeks is not medically necessary.

Toxicology-Urine Drug Screen: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Pain Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug testing Page(s): 43.

Decision rationale: The injured worker has a history of back and knee pain. The CA MTUS guidelines recommend drug testing as an option, using a urine drug screen to assess for the use or the presence of illegal drugs including the aberrant behavior and opioid monitoring to rule out non-compliant behavior. It was noted the rationale for urine drug screen is for medication compliance; it was also noted the injured worker had xxx previous drug screens in 20xx. There is a lack of clinical information indicating the injured worker was at risk for medications misuse or displayed aberrant behaviors. Thus, the drug test would be medically unnecessary. Hence, the request is non-certified. Within the clinical information, the injured worker had 2

consecutive urine drug screens indicating medication compliance. It is unclear why the injured worker needs urine toxicology as the injured worker is only on Tramadol. There is no evidence of drug abuse according to the records. There is a lack of documentation of aberrant behavior. As such, the request for Toxicology-Urine Drug Screen is not medically necessary.

Interferential Unit-rental or purchase not specified: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines IF Unit Page(s): 119.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118.

Decision rationale: The injured worker has a history of back and knee pain. The CA MTUS guidelines do not recommend the use of interferential current stimulation (ICS) as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. There is a lack of documentation of returning to work. There is a lack of documentation of a home exercise program or medications. As such, the request for Interferential Unit-rental or purchase not specified is not medically necessary.

Motorized Cold Therapy Unit-rental or purchase not specified: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Continuous-flow cryotherapy.

Decision rationale: The injured worker has a history of back and knee pain. The Official Disability Guidelines (ODG) recommended as an option after surgery, but not for nonsurgical treatment. Postoperative use generally may be up to 7 days, including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage; however, the effect on more frequently treated acute injuries (e.g., muscle strains and contusions) has not been fully evaluated. Continuous-flow cryotherapy units provide regulated temperatures through use of power to circulate ice water in the cooling packs. Complications related to cryotherapy (i.e., frostbite) are extremely rare but can be devastating. There is lack of documentation for the use of a motorized cold therapy unit versus a cold pack. As such, the request for Motorized Cold Therapy Unit-rental or purchase not specified is not medically necessary.

Physiotherapy Functional Capacity Evaluation: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability

Prevention and Management Page(s): 89-92.

Decision rationale: The injured worker has a history of back and knee pain. The CA MTUS/ACOEM guidelines recognize the functional capacity exam/evaluation as a supported tool for assessing an injured worker's function and functional recovery. There is a lack of documentation of the rationale for a Functional Capacity Evaluation. As such, the request for Physiotherapy Functional Capacity Evaluation is not medically necessary.

Topical Flurbiprofen/Capsaicin/Camphor 10%/0.025%, 2%, 1% (120gm): 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; Flurbiprofen; Capsaicin Page(s): 111; 72; 28.

Decision rationale: The injured worker has a history of back and knee pain. The California MTUS guidelines indicate that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Flurbiprofen is classified as a non-steroidal anti-inflammatory agent. This agent is not currently FDA approved for a topical application. FDA approved routes of administration for Flurbiprofen include oral tablets and ophthalmologic solution. Capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. Flurbiprofen and capsaicin have been used and failed. There is a request for 2 topical agents that both have said medications, which are not approved. There is a lack of documentation as to the body part specified. As such, the request for Topical Flurbiprofen/Capsaicin/Camphor 10%/0.025%, 2%, 1% (120 gm) is not medically necessary.

Topical Ketoprofen/Cyclobenzaprine/Lidocaine 10%, 3%, 5% (120gm): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ketoprofen; Cyclobenzaprine; Lidocaine Page(s): 111-113; 41.

Decision rationale: The injured worker has a history of back and knee pain. The California MTUS guidelines indicate that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Flurbiprofen is classified as a non-steroidal anti-inflammatory agent. This agent is not currently FDA approved for a topical application. FDA approved routes of administration for Flurbiprofen include oral tablets and ophthalmologic solution. Capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. Flurbiprofen and capsaicin have been used and failed. There is a request for 2 topical agents that both have said medications, which are not approved. There is a lack of documentation as to the body part specified. As such, the request for Topical

Flurbiprofen/Capsaicin/Camphor 10%/0.025%, 2%, 1% (120 gm) is not medically necessary.

Prilosec-Omeprazole 20mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68.

Decision rationale: The CA MTUS guidelines recommend the use of proton pump inhibitors if there is a history of gastrointestinal bleeding or perforations, a prescribed high dose of NSAIDs and a history of peptic ulcers. There is also a risk with long-term utilization of PPI (> 1 year) which has been shown to increase the risk of hip fracture. There is lack of frequency within the request. It is unclear why the patient is receiving Prilosec. There is no indication of gastrointestinal events at this time. As such, the request for Prilosec-Omeprazole 20 mg #60 is not medically necessary.

Flexeril-Cyclobenzaprine 7.5mg #60: Upheld

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

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

Decision rationale: The injured worker has a history of back and knee pain. The CA MTUS guidelines recommend cyclobenzaprine (Flexeril) as an option, using a short course of therapy. Cyclobenzaprine is a skeletal muscle relaxant and a central nervous system (CNS) depressant. There is a lack of clinical information provided indicating how long the injured worker has used cyclobenzaprine, the guidelines recommend cyclobenzaprine as a short course of therapy. There is a lack of documentation as to the frequency of the request. As such, the request for Flexeril-Cyclobenzaprine 7.5 mg #60 is not medically necessary.

Theramine #90, 2 bottles: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Medical Food.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Medical Food.

Decision rationale: The Official Disability Guidelines (ODG) recommended as indicated below. Defined as "a food which is formulated to be consumed or administered enterally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation." To be considered the product must, at a minimum, meet the following criteria: the product must be a food for oral or tube feeding; the

product must be labeled for dietary management of a specific medical disorder, disease, or condition for which there are distinctive nutritional requirements; the product must be used under medical supervision. Medical foods are exempted from the labeling requirements for health claims and nutrient content claims under the Nutrition Labeling and Education Act of 1990. Medical foods do not have to be registered with the FDA. Medical foods do not have support by peer-reviewed literature. As such, the request for Theramine #90, 2 bottles is not medically necessary.

Sentra PM #60, 1 bottle: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Medical Food.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Medical Food.

Decision rationale: The Official Disability Guidelines (ODG) recommended as indicated below. Defined as "a food which is formulated to be consumed or administered enterally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation." To be considered the product must, at a minimum, meet the following criteria: the product must be a food for oral or tube feeding; the product must be labeled for dietary management of a specific medical disorder, disease, or condition for which there are distinctive nutritional requirements; the product must be used under medical supervision. Medical foods are exempted from the labeling requirements for health claims and nutrient content claims under the Nutrition Labeling and Education Act of 1990. Medical foods do not have to be registered with the FDA. Medical foods do not have support by peer-reviewed literature. As such, the request for Sentra PM #60, 1 bottle is not medically necessary.

Sentra AM #60, 1 bottle: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Medical Food.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Medical Food.

Decision rationale: The Official Disability Guidelines (ODG) recommended as indicated below. Defined as "a food which is formulated to be consumed or administered enterally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation." To be considered the product must, at a minimum, meet the following criteria: the product must be a food for oral or tube feeding; the

product must be labeled for dietary management of a specific medical disorder, disease, or condition for which there are distinctive nutritional requirements; the product must be used under medical supervision. Medical foods are exempted from the labeling requirements for health claims and nutrient content claims under the Nutrition Labeling and Education Act of 1990. Medical foods do not have to be registered with the FDA. Medical foods do not have support by peer-reviewed literature. As such, the request for Sentra AM #60, 1 bottle is not medically necessary.

MRI of the bilateral knees: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 341-343. Decision based on Non-MTUS Citation Official Disability Guidelines-Knee Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, MRI's (magnetic resonance imaging).

Decision rationale: The injured worker has a history of back and knee pain. The CA MTUS/ACOEM guidelines do not recommend MRI studies for ligament collateral tears. The guidelines do recommend MRI study to determine extent of ACL tear preoperatively. The Official Disability Guidelines state soft-tissue injuries (meniscal, chondral surface injuries, and ligamentous disruption) are best evaluated by MRI. Routine use of MRI for follow-up of asymptomatic patients following knee arthroplasty is not recommended. The rationale for the MRI of the knee was not provided. There is a lack of clinical evidence indicating the injured worker has a soft-tissue injury indicative for a MRI. There is a lack of objective findings or physiological evidence indicating specific injury per neurological examination to warrant imaging. There is a lack of documentation as to the necessity of an MRI at this time. As such, the request for MRI of the bilateral knees is not medically necessary.

Consultation with a Neurologist: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Consultations, Page 163.

Decision rationale: The injured worker has a history of back and knee pain. ACOEM guidelines indicate that a referral may be appropriate if the practitioner is uncomfortable with treating a particular cause of delayed recovery. A consultation is intended to aid in assessing the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or examinee's fitness for return to work. A consultant is usually requested to act in an advisory capacity, but may sometimes take full responsibility for investigating and/or treating a patient within the doctor-patient relationship. There is a lack of documentation as to

the rationale for a neurologist referral. As such, the request for Consultation with a Neurologist is not medically necessary.