

Case Number:	CM14-0158172		
Date Assigned:	10/01/2014	Date of Injury:	12/20/2013
Decision Date:	10/28/2014	UR Denial Date:	09/09/2014
Priority:	Standard	Application Received:	09/26/2014

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 Interventional Spine 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 a 55 years old female with an injury date on 12/20/2013. Based on the 08/26/2014 progress report provided by [REDACTED], the diagnoses are lumbosacral musculoligamentous strain/sprain with radiculitis; rule out lumbosacral spine discogenic disease, right out right wrist carpal tunnel syndrome, right wrist tenosynovitis, right wrist ganglion cyst, left ankle strain/sprain and rule out left foot internal derangement. According to this report, the patient complains of pain in the lower back, left ankle/foot and numbness in the right wrist/hand. Pain is rated at an 8-9/10 for the lower back and as an 8/10 for the wrist/hand and foot/ankle. Physical exam reveals grade 3-4 tenderness over the lumbar paraspinal muscles with restricted range of motion. There is grade 2-3 tenderness to palpation over the right wrist/hand and left foot/ankle. The 07/29/2014 report indicates straight leg raise test is positive bilaterally. Trigger noted is noted at the lumbar spine. There were no other significant findings noted on this report. The utilization review denied the request on 09/09/2014. [REDACTED] is the requesting provider, and he provided treatment reports from 07/29/2014 to 08/26/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

One X-ray of teh right wrist and left foot: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 372 - 374.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 268. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG Ankle and foot chapter under Radiography

Decision rationale: According to the 08/26/2014 report by [REDACTED] this patient presents with pain in the lower back, left ankle/foot and numbness in the right wrist/hand but the treating physician's report and request for authorization containing the request is not included in the file. The physician is requesting one x-ray of the right wrist and left foot. Regarding wrist X-ray, ACOEM guidelines state indications for x-ray are as follow, tenderness of the snuff box (radial-dorsal wrist), and acute injury to the metacarpophalangeal joint of the thumb, peripheral nerve impingement, and recurrence of a symptomatic ganglion that has been previously aspirated or a trigger finger that has been previously treated with local injections. In this case, the physician does not mention that the patient has the above indication. No tenderness of the snuffbox, no acute injury to the metacarpophalangeal joint of the thumb, no peripheral nerve impingement, and no recurrence of a symptomatic ganglion. Recommendation is for denial. Regarding foot/ankle x-ray, ODG guidelines states x-ray is indicates for chronic ankle pain, suspected of osteochondral injury, tendinopathy, ankle instability, pain of uncertain etiology, Reiter's disease, tarsal tunnel syndrome, Freiberg's disease and Morton's neuroma. The utilization review denial letter states "Prior X-ray of the left foot and or ankle was taken and the evaluation and diagnosis did not reflect that there were any conditions that were suspect for bony PR pathological findings that would be evident on plain films." Review of reports, there were no mentions of osteochondral injury, tendinopathy, ankle instability, pain of uncertain etiology, Reiter's disease, tarsal tunnel syndrome, Freiberg's disease, and Morton's neuroma. Furthermore, the physician does not explain why another set x-ray of the left ankle/foot is needed. Recommendation is for denial.

One physical performance functional capacity evaluation (FCE): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Fitness for Duty Chapter

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) ACOEM Guidelines FCE, page 137

Decision rationale: According to the 08/26/2014 report by [REDACTED] this patient presents with pain in the lower back, left ankle/foot and numbness in the right wrist/hand. The physician is requesting one physical therapy performance functional capacity evaluation (FCE) but the treating physician's report and request for authorization containing the request is not included in the file. Regarding Functional/Capacity Evaluation, ACOEM Guidelines page 137 states, "The examiner is responsible for determining whether the impairment results in functional limitations... The employer or claim administrator may request functional ability evaluations... These assessments also may be ordered by the treating or evaluating physician, if the physician feels the information from such testing is crucial. There is little scientific evidence confirming

that FCEs predict an individual's actual capacity to perform in the workplace." In this case, the physician does not explain why FCE is crucial. It is not requested by the employer or the claims administrator. The FCE does not predict the patient's actual capacity to perform in the workplace. Recommendation is for denial.

One interferential unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Fitness for Duty, Interferential Current Stimulation (ICS)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines One interferential unit Page(s): 118-120.

Decision rationale: According to the 08/26/2014 report by [REDACTED] this patient presents with pain in the lower back, left ankle/foot and numbness in the right wrist/hand. The physician is requesting 1 interferential unit but the treating physician's report and request for authorization containing the request is not included in the file. The MTUS Guidelines page 118 to 120 states that interferential current stimulation is not recommended as an isolated intervention. MTUS also recommends trying the unit for one-month before a home unit is provided if indicated. Indications are pain ineffectively controlled with medication; history of substance abuse; post-operative use; unresponsive to conservative measures. In this case, the patient does not present with a specific indication for IF unit and has not trialed the unit for a month to determine effectiveness. Recommendation is for denial.

Twelve sessions of physical therapy treatments with evaluation for lumbar spine, right wrist and left foot: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine, Excessive Therapy Page(s): 98-99, 8.

Decision rationale: According to the 08/26/2014 report by [REDACTED] this patient presents with pain in the lower back, left ankle/foot and numbness in the right wrist/hand. The physician is requesting 12 sessions of physical therapy treatments with evaluation for lumbar spine, right wrist and left foot. For physical medicine, the MTUS guidelines recommend for myalgia and myositis type symptoms 9-10 visits over 8 weeks. Review of available records show no therapy reports and there is no discussion regarding the patient's progress. If the patient did not have any recent therapy, a short course of therapy may be reasonable for declined function or a flare-up of symptoms. However, the physician does not discuss the patient's treatment history or the reasons for requested additional therapy. No discussion is provided as to why the patient is not able to perform the necessary home exercises. MTUS page 8 requires that the physician provide monitoring of the patient's progress and make appropriate recommendations. Furthermore, the requested 12 sessions exceed what is allowed by MTUS. Recommendation is for denial.

One prescription of Gabapentin 10%/Amitriptyline 10%/Dextromethorphan 10%, 240 grams: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical creams Page(s): 111.

Decision rationale: According to the 08/26/2014 report by [REDACTED] this patient presents with pain in the lower back, left ankle/foot and numbness in the right wrist/hand. The physician is requesting 1 prescription of Gabapentin 10%, Amitriptyline Dextromethorphan 10% 240grams. Regarding topical compounds, MTUS states that if one of the compounded products is not recommended then the entire compound is not recommended. In this case, Gabapentin and Amitriptyline are not recommended for topical formulation. Recommendation is for denial.

One prescription of Flurbiprofen 20%/Tramadol 20%, 240 grams: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical creams Page(s): 111.

Decision rationale: According to the 08/26/2014 report by [REDACTED] this patient presents with pain in the lower back, left ankle/foot and numbness in the right wrist/hand. The physician is requesting 1 prescription Flurbiprofen 20% Tramadol 20%, 240 gm. regarding topical compounds; MTUS states that if one of the compounded products is not recommended then the entire compound is not recommended. In this case, Tramadol is not recommended for topical formulation. Recommendation is for denial.