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| Case Number: | CM14-0021290 | | |
| Date Assigned: | 05/07/2014 | Date of Injury: | 12/17/2013 |
| Decision Date: | 07/23/2014 | UR Denial Date: | 02/03/2014 |
| Priority: | Standard | Application Received: | 02/20/2014 |

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 Internal 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 injured worker is a 45 year old male who sustained an injury on 12/17/13 when he was struck by a tram cart getting caught between a cart and a steel dumpster. The injured worker had been followed for complaints of neck pain and low back pain. The initial work up was negative for any evidence of fractures. Prior medication use was pertinent for ibuprofen. The injured worker was seen on 01/14/14 with continuing complaints of neck pain posteriorly radiating to the shoulders and shoulder blades and mid and low back pain radiating to the buttocks that was worsened with any twisting walking lifting bending or stooping. On physical examination the injured worker ambulated with antalgic gait. The range of motion was limited in the cervical spine in all planes. No specific neurological deficits in the upper extremities were noted. The injured worker had significant loss of lumbar range of motion in all planes. No clear motor weakness in the lower extremities was identified. The requested functional capacity evaluation compounded topical medications including Amitriptyline, Dextromethorphan, capsaicin, menthol, camphor, Tramadol, Flurbiprofen, and Diclofenac; muscle stimulator; a transcutaneous electrical nerve stimulation (TENS) unit trial; and aqua release cold therapy system were not recommended by utilization review on undetermined date. The provided utilization review records had no determination date listed.

IMR ISSUES, DECISIONS AND RATIONALES

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

(FCE) FUNCTIONAL CAPACITY EVALUATION: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 7: Independent Medical Examinations and Consultations pages 137-138 and 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 Official Disability Guidelines (ODG), Fitness for Duty Chapter, functional capacity evaluation.

Decision rationale: In regards to the requested functional capacity evaluation, there is no indication for the use of this testing at this time. There was no indication from the clinical records that there were any concerns regarding work restrictions for the injured worker. It is unclear if there had ever been failure of the injured worker to return to work. There was also no indication that the injured worker was considered at or near maximum medical improvement to support functional capacity evaluations. Given the lack of any clear indications for functional capacity evaluation at this time, the request cannot be deemed as medically necessary based on Official Disability Guidelines (ODG).

COMPOUND CREAMS: AMITRIPTYLINE 4%, DEXTROMETHORPHAN 10%, TRAMADOL 20% CREAM: 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 compounded topical medication cannot be recommended as medically necessary based on clinical documentation submitted for review and based on Chronic Pain Medical Treatment Guidelines. The use of topical compounded medications in the treatment of chronic pain is largely considered experimental/investigational by current evidence based guidelines. There is limited evidence in the clinical literature establishing that compounded topical use of prescribed oral medications results in any significant functional improvement as compared to oral counterparts. The use of Amitriptyline, Dextromethorphan, and Tramadol in transdermal creams is not approved by the FDA. There is no indication the injured worker had any substantial side effects or could not tolerate oral medications. Given the lack of any clinical indications for the use of this topical compounded medication, the request cannot be deemed as medically necessary. Therefore the request is not medically necessary.

COMPOUND CREAM: CAPSAICIN 0.0375%, MENTHOL 10%, CAMPHOR 2.5%, TRAMADOL 20%: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesic Page(s): 111.

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

Decision rationale: The compounded topical medication cannot be recommended as medically necessary based on clinical documentation submitted for review and based on Chronic Pain Medical Treatment Guidelines. The use of topical compounded medications in the treatment of chronic pain is largely considered experimental/investigational by current evidence based guidelines. There is limited evidence in the clinical literature establishing that compounded topical use of prescribed oral medications results in any significant functional improvement as compared to oral counterparts. The use of Tramadol in transdermal creams is not approved by the FDA. There is no indication the injured worker had any substantial side effects or could not tolerate oral medications. Given the lack of any clinical indications for the use of this topical compounded medication, the request is not medically necessary.

COMPOUND CREAM: FLURBIPROFEN 25%, DICLOFENAC 10%: 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 compounded topical medication cannot be recommended as medically necessary based on clinical documentation submitted for review and based on Chronic Pain Medical Treatment Guidelines. The use of topical compounded medications in the treatment of chronic pain is largely considered experimental/investigational by current evidence based guidelines. There is limited evidence in the clinical literature establishing that compounded topical use of prescribed oral medications results in any significant functional improvement as compared to oral counterparts. The use of Flurbiprofen in transdermal creams is not approved by the FDA. There is no indication the injured worker had any substantial side effects or could not tolerate oral medications. Given the lack of any clinical indications for the use of this topical compounded medication, the request cannot be deemed as medically necessary.

MUSCLE STIMULATOR: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular Electrical Stimulation (NMES Devices).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 113-117.

Decision rationale: In regards to the request for a muscle stimulator, the clinical documentation submitted for review did not specify what kind of muscular stimulator was recommended. There was a request included for trial of TENS unit which is a type of muscle stimulator. This request appears to be duplicative and would not be supported as medically necessary.

TRIAL OF TENS (TRANSCUTANEOUS ELECTRICAL NERVE STIMULATION)

UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 116.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy Page(s): 113-117.

Decision rationale: In regards to the request for a TENS unit trial, the prior utilization review recommended modification of this request to 30 day trial. Given the non-specific trial request for TENS unit this reviewer would have agreed with the prior utilization review that modified the trial to 30 days only as indicated by guidelines. The unspecified request for a TENS unit trial cannot be recommended as medically necessary based on Chronic Pain Medical Treatment Guidelines.

AQUA RELIEF SYSTEM (COLD THERAPY UNIT) HOT AND COLD 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).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, hot/cold packs.

Decision rationale: In regards to the request for a hot and cold therapy unit, this reviewer would not have recommended this durable medical equipment is medically necessary based on Official Disability Guidelines (ODG). Hot and cold therapy units are typically utilized post-operatively in the shoulders and knees on a rental basis. There is no indication from the clinical notes that a hot and cold therapy unit would be any more beneficial for this injured worker as compared to standard hot and cold packs available commercially available over the counter. Therefore the request is not medically necessary.