

Case Number:	CM14-0025752		
Date Assigned:	07/23/2014	Date of Injury:	08/28/2011
Decision Date:	09/10/2014	UR Denial Date:	01/28/2014
Priority:	Standard	Application Received:	02/28/2014

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 low back and bilateral knee pain with derivative complaints of anxiety disorder and mood disturbance reportedly associated with an industrial injury of August 28, 2011. Thus far, the applicant has been treated with the following: Analgesic medications; attorney representation; transfer of care to and from various providers in various specialties; earlier knee arthroscopy; MRI imaging of the left knee of June 30, 2013, notable for degeneration of the meniscus without evidence of a discrete tear and arthritic changes; MRI imaging of the right knee of June 30, 2013, also notable for degeneration of the meniscus without evidence of discrete tear; topical compounds; oral suspensions; a cane; and extensive periods of time off of work. In a Utilization Review Report dated January 28, 2014, the claims administrator denied a request for functional improvement measures/functional capacity testing, facet blocks, physical therapy, Deprizine, Dicopanol, Fanatrex, Synapryn, Tabradol, Flurbiprofen, Gabapentin, topical Ketoprofen, topical Cyclophene, manipulative therapy, shock wave therapy, a knee surgery consultation, topical patches, numerous MRIs, and a diskogram. A pain management consultation, however, was approved. The applicant's attorney subsequently appealed. In a November 20, 2013 progress note, the applicant was placed off of work, on total temporary disability. Manipulative therapy, physical therapy, functional capacity testing, various and sundry topical compounds and oral suspensions, and a pain management consultation were endorsed. The applicant reported 5-7/10 low back and knee pain with associated anxiety, depression, and psychological stress. Eighteen sessions of physical therapy were endorsed. The applicant was also placed off of work, on total temporary disability, on an earlier progress note of September 27, 2013, at which point various oral medications and topical compounds were again furnished. There was no mention of any issues with reflux, heartburn, and/or dyspepsia.

The applicant again presented with chronic low back and bilateral knee pain with associated anxiety, psychological stress, and depression.

IMR ISSUES, DECISIONS AND RATIONALES

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

Functional Improvement Measurement, complete every 30 days (lumbar, bilateral knees) 1 times per week for 6 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation, Chronic Pain Treatment Guidelines Functional Improvement Measures.

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

Decision rationale: While the MTUS Guideline in ACOEM Chapter 2, page 21 does suggest considering a functional capacity evaluation when necessary to translate medical impairment into limitations and restrictions, in this case, however, the applicant is off of work, on total temporary disability. The applicant does not seemingly have a job to return to. It is not clear what role functional capacity testing/functional improvement measures either every 30 days or once a week would play here, given all of the foregoing. It is not clear how functional capacity testing/functional improvement measures would alter or influence the treatment plan, particularly the applicant is not intent on returning to the workplace and/or does not have a job to return to. Therefore, the request is not medically necessary.

Facet blocks, discogram with post contrast CT (computed tomography): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG-TWC) Low Back Procedure Summary (last updated 12/27/13).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

Decision rationale: As noted in the MTUS-Adopted ACOEM Guidelines in Chapter 12, Table 12-8, page 309, facet joint injections, as are being proposed here, are deemed "not recommended." No rationale or applicant-specific information was proffered so as to offset the unfavorable ACOEM recommendation. It was not clearly stated why the attending provider suspected a diagnosis of facetogenic pain or diskogenic pain here. Similarly, ACOEM's position in Chapter 12, Table 12-8, and page 309 on diskography or CT diskography is "not recommended." In this case, it is further noted that no rationale for diskography testing in the face of the unfavorable ACOEM recommendation was proffered by the attending provider. It was not clearly stated, for instance, that the applicant was actively considering or contemplating any kind of lumbar spine surgery and/or that the applicant had had earlier equivocal or non-

diagnostic lumbar MRI imaging. For all of the stated reasons, then, both the facet blocks and diskogram are not medically necessary.

Functional Capacity Evaluation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation, Chronic Pain Treatment Guidelines Functional Measures of Improvement.

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

Decision rationale: While the MTUS Guideline in ACOEM Chapter 2, page 21 does suggest considering functional capacity testing when necessary to translate medical impairment into limitations and restrictions, in this case, however, as with the preceding request, no rationale for functional capacity testing was proffered by the attending provider. The applicant is off of work, on total temporary disability. The applicant does not appear to have a job to return to. It is unclear what role functional capacity testing would serve in this context. Therefore, the request is not medically necessary.

Retrospective Physical Therapy performed (DOS; 12/17/13 and 12/24/13) to the lumbar spine and bilateral knees 3 times per week for 6 weeks: Upheld

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

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

Decision rationale: The 18-session course of treatment already performed, in and of itself represents treatment in excess of the 9- to 10-session course recommended on page 99 of the MTUS Chronic Pain Medical Treatment Guidelines for myalgias and myositis of various body parts, the issue reportedly present here. It is further noted that page 8 of the MTUS Chronic Pain Medical Treatment Guidelines further qualifies this recommendation by noting that there must be demonstration of functional improvement at various milestones in the treatment program so as to justify continued treatment. In this case, the applicant's remaining off of work, coupled with the applicant's dependence on numerous forms of medical treatment, including various and sundry oral and topical medications, taken together, imply a lack of functional improvement as defined in MTUS 9792.20f despite completion of the 18 sessions of physical therapy in question. Therefore, the request was not medically necessary.

Prospective Physical Therapy to the lumbar spine and bilateral knees 3 times per week for 6 weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 99, 8.

Decision rationale: The applicant has had extensive amounts of prior physical therapy, already in excess of the 9- to 10-session course recommended on page 99 of the MTUS Chronic Pain Medical Treatment Guidelines for myalgias and myositis of various body parts. The applicant has, however, failed to demonstrate any lasting benefit or functional improvement through the same. The applicant remains off of work, on total temporary disability. The applicant remains highly reliant and highly dependent on various forms of medical treatment, including numerous oral and topical medications. All of the above, taken together, argue against any functional improvement achieved to date despite completion of extensive prior physical therapy. Therefore, the request for 18 prospective sessions of physical therapy is not medically necessary.

Retrospective usage of Deprizine 12mg/ml, 500ml (1x6): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (Non-Steroidal Anti-Inflammatory Drugs). Decision based on Non-MTUS Citation <http://www.drugs.com/pro/deprizine.html>.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines page 69, NSAIDs, GI Symptoms, and Cardiovascular Risk topic. Page(s): 69.

Decision rationale: While page 69 of the MTUS Chronic Pain Medical Treatment Guidelines does support provision of H2 antagonists such as Deprizine (ranitidine) to combat issues with NSAID-induced dyspepsia. In this case, however, the documentation on file does not establish the presence of any active symptoms of reflux, heartburn, and/or dyspepsia, either NSAID-induced or stand-alone. Therefore, the request was not medically necessary.

Retrospective request for prescription of Dicopanol 5mg/ml 250ml (1x6): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MD Consult Drug Monograph (last updated 12/31/2011), Diphenhydramine (Benadryl).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Library of Medicine (NLM), Diphenhydramine Drug Guide.

Decision rationale: The MTUS does not address the topic. While the National Library of Medicine (NLM) does support provision of Diphenhydramine (Dicopanol) in the treatment of allergic reactions, motion sickness, and/or parkinsonism, in this case, however, there was no mention of any active issues with parkinsonism, motion sickness, and/or allergic reactions which would support provision of Diphenhydramine. Therefore, the request was not medically necessary.

Retrospective usage of Fanatrex 25mg/ml 420ml (1x6): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy Drugs. Decision based on Non-MTUS Citation <http://www.drugs.com/profanatrex.html>.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines page 19, Gabapentin section. Page(s): 19.

Decision rationale: As noted on page 19 of the MTUS Chronic Pain Medical Treatment Guidelines, applicants using Fanatrex (Gabapentin) should be asked at each visit as to whether there has been any improvements in pain or function with the same. In this case, the fact that the applicant is off of work, on total temporary disability, implies previous usage of Fanatrex was, in fact, unsuccessful in terms of the functional improvement parameters established in MTUS 9792.20f. No discussion of Fanatrex efficacy was incorporated into any of the attending provider's progress notes. Therefore, the request was not medically necessary.

Retrospective usage of Synaprn 10mg/ml 500ml (1x6): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids (therapeutic trial).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines page 80, When to Continue Opioids topic. Page(s): 80. Decision based on Non-MTUS Citation . National Library of Medicine (NLM), Synapryn Medication Guide.

Decision rationale: As noted previously, Synapryn, per the National Library of Medicine (NLM), is an amalgam of Tramadol and glucosamine. Tramadol is a synthetic opioid. As noted on page 80 of the MTUS Chronic Pain Medical Treatment Guidelines, the cardinal criteria for continuation of opioid therapy include evidence of successful return to work, improved functioning, and/or reduced pain achieved as a result of the same. In this case, however, the applicant is off of work. There has been no mention of any improvements in pain or function achieved as a result of ongoing Synapryn usage. Therefore, the request was not medically necessary.

Retrospective usage of Tabradol 1mg/ml 250ml (2x6): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Procedure Summary (last updated 10/14/13), non-sedating muscle relaxants.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines pages 111-113. Page(s): 111-113. Decision based on Non-MTUS Citation National Library of Medicine (NLM), Tabradol Medication Guide.

Decision rationale: Tabradol, per the National Library of Medicine, is an amalgam of Cyclobenzaprine and MSM. However, as noted on page 113 of the MTUS Chronic Pain Medical Treatment Guidelines, muscle relaxants such as Cyclobenzaprine are not recommended for topical compound formulation purposes. Since one or more ingredients in the compound are not recommended, the entire compound is not recommended, per page 111 of the MTUS Chronic Pain Medical Treatment Guidelines. Therefore, the request was not medically necessary.

Retrospective usage of Flurbiprofen: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Inflammatory Medications topic. Page(s): 22, 7.

Decision rationale: While page 22 of the MTUS Chronic Pain Medical Treatment Guidelines does acknowledge that anti-inflammatory medications such as Flurbiprofen do represent the traditional first line of treatment for various chronic pain conditions, including the chronic pain syndrome reportedly present here, this recommendation is qualified by commentary made on page 7 of the MTUS Chronic Pain Medical Treatment Guidelines to the fact that an attending provider should incorporate some discussion of medication efficacy into his choice of recommendations. In this case, the fact that the applicant remains off of work, on total temporary disability, despite ongoing usage of Flurbiprofen, and remains highly reliant and highly dependent on numerous other forms of treatment, including physical therapy, extracorporeal shock wave therapy, etc. taken together, imply a lack of functional improvement as defined in MTUS 9792.20f despite prior usage of the same. Therefore, the request was not medically necessary.

Retrospective (DOS: 12/26/13) usage of Terocin Patches (1x6): Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47, Chronic Pain Treatment Guidelines page 111. Page(s): 111.

Decision rationale: As noted in the MTUS-Adopted ACOEM Guidelines in Chapter 3, page 47, oral pharmaceuticals are a first-line palliative method. 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 usage of topical agents and/or topical compounds such as Terocin which are, per page 111 of the MTUS Chronic Pain Medical Treatment Guidelines "largely experimental." Therefore, the request was not medically necessary.

Shockwave therapy to the lumbar spine (1x6): 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-TWC), Low Back Procedure Summary (last updated 12/27/13), Shock Wave Therapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines page 123, Therapeutic Ultrasound topic Page(s): 123.

Decision rationale: Extracorporeal shock wave therapy is a subset of therapeutic ultrasound therapy. However, page 123 of the MTUS Chronic Pain Medical Treatment Guidelines notes that therapeutic ultrasound is "not recommended." In this case, no rationale for pursuit of extracorporeal shock wave therapy, a form of ultrasound therapy, was provided in the face of the unfavorable MTUS position on the same. Therefore, the request is not medically necessary.

MRI of the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG-TWC), Low Back Procedure Summary (last updated 12/27/13), MRIs.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304.

Decision rationale: As noted in the MTUS-adopted ACOEM Guidelines in Chapter 12, page 304, imaging studies should be reserved for cases in which surgery is being considered or red flag diagnoses are being evaluated. In this case, there is no evidence that the applicant is actively considering or contemplating surgery. Therefore, the requested lumbar MRI imaging is not medically necessary.

MRI of the right knee: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 335. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG-TWC), Knee and Leg Procedure Summary (last updated 01/09/13), MRIs.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 347.

Decision rationale: While the MTUS Guideline in ACOEM Chapter 13, Table 13-6, page 347 does recommend MRI imaging to determine the extent of an ACL tear preoperatively, in this case, however, there is no evidence that the applicant is actively considering or contemplating any kind of knee surgery. There is no indication that knee MRI imaging would alter the treatment. It was further noted that earlier knee MRI imaging failed to recover any discrete pathology which might be amenable to surgical correction. Therefore, the knee MRI was/is not medically necessary.