

Case Number:	CM14-0025867		
Date Assigned:	06/20/2014	Date of Injury:	09/27/2013
Decision Date:	07/29/2014	UR Denial Date:	02/18/2014
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 Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Minnesota. 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 with a reported date of injury on 09/27/2014. The mechanism of injury was not provided within the documentation available for review. The injured worker presented with right wrist pain rated at 6/10 and right foot pain rated at 5/10. The urine drug screen dated 12/04/2013 revealed to be consistent with medications prescribed. The MRI of the right ankle dated 02/26/2014, revealed posterior tibial tendon tenosynovitis, flexor tenosynovitis, Achilles tendon tendinosis and minimal fluid anterior to the tibiotalar joint. According to the clinical note dated 05/15/2014, the physician indicated he was requesting continued physical therapy 2 times 4 weeks. The result of previous physical therapy was not available for review. Within the clinical note the physician indicated that the injured worker had decreased range of motion with pain. Injured worker's diagnosis included right wrist cyst and nonunion fracture, right foot partial amputation tenosynovitis and coccyx contusion. The injured worker's medication regimen included Naproxen, Omeprazole, and Hydrocodone. Request for Authorization for urine drug screen, orthopedic evaluation, physiotherapy; (8) sessions (2x4), right foot, Omeprazole 20 mg #30, Flurlido-A 240 gm, Flurlido-A 30 gm, Ultraflex-G240 gm and Ultraflex-G 30 gm was submitted on 02/25/2014. The rationale for the request was not provided within the clinical information available for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physiotherapy; eight (8) sessions (2x4), right foot: Upheld

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

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

Decision rationale: According to the California MTUS Guidelines, physical medicine is recommended. Active therapy is based on the philosophy that therapeutic exercise and or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. Injured workers are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. In addition, the guidelines recommend 8 to 10 visits over a 4 week period. The clinical information provided for review indicates the physician requested continued physical therapy. There is lack of documentation related to results of previous physical therapy. In addition, there is lack of documentation related to the injured worker's functional deficits to include range of motion values. Therefore, the request for physiotherapy; eight (8) sessions (2x4), right foot is not medically necessary.

OMEPRAZOLE 20MG #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & Cardiovascular Risk.

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

Decision rationale: The California MTUS Guidelines recommend the use of proton pump inhibitors with injured workers who are at risk for gastrointestinal events. To determine if the injured worker is at risk for gastrointestinal events would include the injured worker is greater than 65 years old, history of peptic ulcer, GI bleeding or perforation, concurrent use of ASA, corticosteroids, and/or an anticoagulant or high dose/multiple NSAID use. The clinical information provided for lacks documentation of GI risk factors or sign and symptoms of GI upset. There is a lack of documentation related to the therapeutic benefit of the ongoing use of omeprazole. In addition, the request as submitted failed to provide frequency and directions for use. Therefore, the request for omeprazole 20 mg #30 is not medically necessary.

FLURLIDO-A -240GM: 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): 111-112.

Decision rationale: The California MTUS Guidelines state that topical analgesics are recommended as an option. Although, largely experimental in use with few randomized controlled trials to determine effectiveness or safety. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Many agents are compounded as monotherapy or in combination for pain control. There is little to no research to support the use of many of these agents. The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it would be useful for the specific therapeutic goal required. In addition, the California MTUS Guidelines state that nonsteroidal anti-inflammatory agents trials have been inconsistent and most studies are small and of short duration. Topical NSAIDS have been shown to be superior during the first 2 weeks of treatment for osteoarthritis, but with a diminishing effect over another 2 week period. The guidelines state that Lidocaine is recommended for localized peripheral pain after there has been evidence of a trial of first line therapy. Topical Lidocaine in the formulation of a dermal patch called Lidoderm has been designated for orphan status by the FDA for neuropathic pain. No other commercially approved topical formulations of Lidocaine (whether creams, lotions, or gels) are indicated for neuropathic pain. In addition, the guidelines state that any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. The clinical information provided for review lacks documentation of the injured worker's functional deficits to include range of motion values. The clinical information lacks rationale for the addition of Flurlido to the injured worker's medication regimen. In addition, there is a lack of documentation related to a trial of antidepressants or anticonvulsants. The guidelines do not recommend Lidocaine except for in the form of a Lidoderm patch. In addition, the request as submitted failed to provide frequency, directions and specific site at which the Flurlido was to be utilized. Therefore, the request for Flurlido-A 240 gm is not medically necessary.

FLURLIDO-A 30GM: 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): 111-112.

Decision rationale: The California MTUS Guidelines state that topical analgesics are recommended as an option. Although, largely experimental in use with few randomized controlled trials to determine effectiveness or safety. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Many agents are compounded as monotherapy or in combination for pain control. There is little to no research to support the use of many of these agents. The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it would be useful for the specific therapeutic goal required. In addition, the California MTUS Guidelines state that nonsteroidal anti-inflammatory agents trials have been inconsistent and most studies are small and of short duration. Topical NSAIDS have been shown to be superior during the first 2 weeks of treatment for osteoarthritis, but with a diminishing effect over another 2 week period. The guidelines state that Lidocaine is recommended for localized peripheral pain after there has

been evidence of a trial of first line therapy. Topical Lidocaine in the formulation of a dermal patch called Lidoderm has been designated for orphan status by the FDA for neuropathic pain. No other commercially approved topical formulations of Lidocaine (whether creams, lotions, or gels) are indicated for neuropathic pain. In addition, the guidelines state that any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. The clinical information provided for review lacks documentation of the injured worker's functional deficits to include range of motion values. The clinical information lacks rationale for the addition of Flurlido to the injured worker's medication regimen. In addition, there is a lack of documentation related to a trial of antidepressants or anticonvulsants. The guidelines do not recommend Lidocaine except for in the form of a Lidoderm patch. In addition, the request as submitted failed to provide frequency, directions and specific site at which the Flurlido was to be utilized. Therefore, the request for Flurlido-A 30 gm is not medically necessary.

ULTRAFLEX-G 240GM: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine (and Chondroitin Sulfate) Page(s): 50.

Decision rationale: The California MTUS Guidelines recommend glucosamine Chondroitin sulfate as an option given its low risk, in patients with moderate arthritis pain, especially for knee osteoarthritis. Despite multiple controlled clinical trials of glucosamine in osteoarthritis, controversy on effectiveness related to symptomatic improvement continues. Differences in results originate from the differences in products, study design and study population. The clinical information provided for review lacks documentation of the injured worker's functional deficits to include range of motion values. In addition, the addition of Ultraflex G rationale was not provided within the documentation available for review. The request as submitted failed to provide frequency, directions for use and specific site at which the Ultraflex was to be utilized. Therefore, the request for Ultraflex-G 240 gm is not medically necessary.

ULTRAFLEX-G 30GM: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine (and Chondroitin Sulfate) Page(s): 50.

Decision rationale: The California MTUS Guidelines recommend glucosamine Chondroitin sulfate as an option given its low risk, in patients with moderate arthritis pain, especially for knee osteoarthritis. Despite multiple controlled clinical trials of glucosamine in osteoarthritis, controversy on effectiveness related to symptomatic improvement continues. Differences in results originate from the differences in products, study design and study population. The

clinical information provided for review lacks documentation of the injured worker's functional deficits to include range of motion values. In addition, the addition of Ultraflex G rationale was not provided within the documentation available for review. The request as submitted failed to provide frequency, directions for use and specific site at which the Ultraflex was to be utilized. Therefore, the request for Ultraflex-G 30 gm is not medically necessary.

Urine Drug Screen: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-going Management Page(s): 78.

Decision rationale: California MTUS Guidelines recommend the ongoing management of opioids should include the ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. In addition, the guidelines state that the use of drug screen or inpatient treatment with issues of abuse, addiction, or poor pain control should be included. The clinical information provided for review, lacks documentation of physician concerns related to issues of abuse, addiction, or poor pain control. The urine drug screen dated 12/04/2013 was consistent with medications prescribed. The rationale for the request was not provided within the documentation available for review. Therefore, the request for a urine drug screen is not medically necessary.

Orthopedic Evaluation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Acoem for Independent Medical Examinations and Consultations regarding Referrals, Chapter 7.

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

Decision rationale: The Official Disability Guidelines recommend office visits as determined to be medically necessary. Evaluation and management of outpatient visits to the office of medical doctors play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a healthcare provider is individualized based upon a review of the patient's concerns, signs and symptoms, clinical stability and reasonable physician judgment. The clinical information provided for review lacks documentation of the injured worker's functional deficits to include range of motion values. The rationale for the request is not provided within the documentation available for review. The goal for the orthopedic evaluation is not provided within the documentation available for review. Therefore, the request for orthopedic evaluation is not medically necessary.