

Case Number:	CM14-0026663		
Date Assigned:	06/13/2014	Date of Injury:	06/15/2013
Decision Date:	07/29/2014	UR Denial Date:	02/18/2014
Priority:	Standard	Application Received:	03/03/2014

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 and Rehabilitation and is licensed to practice in Texas. 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 48 year old female whose date of injury is 06/15/13 when she twisted her ankle on a lettuce head on the floor and felt immediate sharp and shooting pain from the knee to the ankle. She complains of left knee and left ankle pain. Medications reportedly are helpful. Physical examination of the left knee on 11/20/13 reported there is positive McMurray's; positive tenderness posterior ligament line; left ankle positive tenderness medial-lateral malleolus. She initially was treated with ice, support/brace, 16 sessions of physical therapy, massage therapy, shock therapy, and medications (prednisone, Relafen). Subsequent medications included Naproxen; Flexeril; Omeprazole. Topical compounded creams also were recommended. Progress report dated 01/08/14 notes that the injured worker presents with complaints with knee pain and left ankle pain. On examination there is tenderness to palpation over the posterior ligament line; tenderness over the medial and lateral malleolus and positive McMurray's. Diagnosis is internal derangement and sprain/strain of the knee and ankle. Treatment plan was for chiropractic care, MRI of left knee and left ankle; acupuncture; DNA testing; x-rays left knee and ankle; topical compounded analgesics.

IMR ISSUES, DECISIONS AND RATIONALES

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

HOT/ COLD THERAPY UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 338. Decision based on Non-MTUS Citation Official Disability Guidelines (OGD).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 338.

Decision rationale: The use of a hot/cold therapy unit is not medically necessary based on the clinical documentation provided for review and current evidence based guideline recommendations. There is limited evidence in the clinical literature to support the use of hot/cold compression therapy sessions for musculoskeletal pain. Although these systems are commonly used for post-operative pain following procedures for the knees, ankles, and shoulders; their efficacy in the treatment of chronic musculoskeletal complaints as compared to standard hot and cold packs is not established. As such, the requested hot/cold therapy unit is not medically necessary.

CHIROPRACTIC TREATMENT; TWELVE (12) VISITS (2X6): Upheld

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

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

Decision rationale: The chiropractic therapy for 12 sessions is not medically necessary based on the clinical documentation provided for review and current evidence based guideline recommendations. Per guidelines, chiropractic therapy can be considered for an initial trial to address a flare up of musculoskeletal complaints. The initial treatment period is recommended for six initial sessions with further sessions dependent on the results of the initial therapy period. The requested 12 sessions of chiropractic therapy would be considered excessive per the Chronic Pain Treatment Guidelines. As such, the request for 12 sessions of chiropractic therapy is not medically necessary.

ACUPUNCTURE TREATMENT; TWELVE (12) VISITS (2X6): Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.1. Acupuncture Medical Treatment Guidelines Page(s): 8-9.

Decision rationale: The use of acupuncture for 12 sessions, is no medically necessary based on the clinical documentation provided for review and current evidence based guideline recommendations. Per guidelines, acupuncture therapy can be considered for an initial trial to address a flare up of musculoskeletal complaints. The initial treatment period is recommended for six initial sessions with further sessions dependent on the results of the initial therapy period. The

requested chiropractic therapy sessions for 12 sessions would be considered excessive the guidelines. As such, the request for twelve acupuncture visits is not medically necessary.

VOLTAGE-ACTUATED SENSORY NERVE CONDUCTION: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Regence Medical Policy, Quantitative Sensory Testing, Policy No. 91.

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

Decision rationale: The use of voltage actuated sensory nerve conduction is not medically necessary based on the clinical documentation provided for review and current evidence based guideline recommendations. There is no indication that the claimant is continuing with a formal rehabilitation program such as a home exercise program or physical therapy in which this passive modality would be used as an adjunct. The use of electrical stimulation as a sole modality for the treatment of musculoskeletal complaints is not supported in the current clinical literature. There is also no evidence of any trials of this durable medical equipment that has resulted in improvement of symptoms, functional improvement, or pain reduction. Therefore, the voltage-actuated sensory nerve conduction is not medically necessary.

240 GM. CAPSAICIN 0.025 PERCENT, FLURBIPROFEN 20%, TRAMADOL 15%, MENTHOL 2%, CAMPHOR 2%, APPLY GENEROUSLY TO AFFECTED AREA THREE TIMES PER DAY: Upheld

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

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

Decision rationale: The request is not recommended as medically necessary based on the clinical documentation provided for review and current evidence based guideline recommendations. The Chronic Pain Treatment Guidelines and US FDA note that the efficacy of compounded medications has not been established through rigorous clinical trials. The FDA requires that all components of compounded topical medication be approved for transdermal use. This compound contains Flurbiprofen and Tramadol which are not approved for transdermal use. The clinical documentation provided did not indicate that there were any substantial side effects with the oral version of the requested medication components. Furthermore, there was no rationale regarding the use of multiple NSAID medications as the injured worker was also utilizing oral NSAIDs. Therefore the request for Capsaicin 0.025 %, Flurbiprofen 20%, Tramadol 15%, Menthol 2%, Camphor 2% topical cream is not medically necessary.

240 GM. GABAPENTIN 10%, LIDOCAINE 5%, TRAMADOL 15%, APPLY GENEROUSLY TO AFFECTED AREA THREE TIMES PER DAY: Upheld

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

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

Decision rationale: The request is not medically necessary based on the clinical documentation provided for review and current evidence based guideline recommendations. The Chronic Pain Treatment Guidelines and US FDA note that the efficacy of compounded medications has not been established through rigorous clinical trials. The FDA requires that all components of compounded topical medication be approved for transdermal use. This compound contains Gabapentin and Tramadol which are not approved for transdermal use. The clinical documentation provided did not indicate that there were any substantial side effects with the oral version of the requested medication components. Furthermore, there was no rationale regarding the use of multiple NSAID medications as the injured worker was also utilizing oral NSAIDs. Therefore, the request for Gabapentin 10%, Lidocaine 5%, Tramadol 15% topical cream is not medically necessary.