

Case Number:	CM14-0064015		
Date Assigned:	08/08/2014	Date of Injury:	10/15/2013
Decision Date:	09/23/2014	UR Denial Date:	04/28/2014
Priority:	Standard	Application Received:	05/06/2014

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:

This is a 23-year-old female with a 10/15/13 date of injury. She injured her neck, arms, chest, back, and left ankle/leg in a car accident on the way back from the bank to deposit cash for her company. Recent progress reports from 4/7/14 through 6/11/14 were handwritten and illegible. According to a comprehensive medical evaluation report dated 3/5/14, the patient complained of intermittent neck pain rated as 4 on a scale of 1 to 10. She complained of continuous upper, middle, and low back pain. She rated the back pain as 7 on a scale of 1 to 10. She also complained of intermittent chest pain with shortness of breath. The pain was rated as 8 on a scale of 1 to 10. She stated that her left ankle and leg were not asymptomatic. Objective findings: tenderness and spasm on the cervical bilateral paraspinals, suboccipital, and upper trapezius; tenderness on the bilateral sternocleidomastoid muscle and scalenes; mild tenderness at C5-C6; tenderness and spasm on the thoracic bilateral paraspinals; tenderness and spasm on the lumbar bilateral paraspinals; tenderness on the bilateral quadratus lumborum, sacroiliac joint, piriformis muscles, sciatic notch, and iliolumbar ligaments; midline tenderness on the L3-L4, L4-L5, L5-S1; tenderness on the left lateral ankle and Achilles. MRI of left ankle dated 5/8/14 revealed posterior tibialis tenosynovitis. MRI of cervical spine dated 5/7/14 revealed C6-7 1.0 mm central disc protrusion, 0 mm in flexion, 1.0 mm in extension, postural changes, non-specific maxillary sinus disease, no other abnormalities noted. MRI of thoracic spine dated 5/7/14 revealed postural changes, no other abnormalities noted. Diagnostic impression: cervical spine sprain/strain with radiation to the bilateral upper extremities, thoracic spine sprain/strain, lumbar spine sprain/strain with radiation to the bilateral lower extremities, chest pain, left ankle sprain/strain, closed head trauma, insomnia. Treatment to date: medication management, activity modification, acupuncture. A UR decision dated 4/28/14 denied the requests for Flurbi/Trama/Cyclo cream, Gaba/Amit/Dextro cream, Terocin patches, Omeprazole 20 mg, MRI

of the cervical spine/thoracic spine/lumbar spine/left ankle, Biotouch IF unit, Cold unit, Eight (8) physical therapy sessions, internal medicine consultation, psychiatric consultation, and neurologist consultation. The request for Hydrocodone 2.5/325 mg was modified to 90 tablets with zero refills for weaning purposes. MRI Regarding Flurbi/Trama/Cyclo and Gaba/Amit/Dextro, there is no rationale for the use of multiple topical creams. It would appear that the patient can tolerate oral medications since she was prescribed several other oral medications. Regarding Terocin patches, there is no clear documentation of failure of anticonvulsants or other first-line agents used in the management of neuropathic pain. There was no rationale for the use of patches in conjunction with several other topical agents. Regarding Omeprazole, there is no evidence provided that the patient suffers from dyspepsia as a result of the present medication regimen. Regarding Hydrocodone 2.5/325 mg, the provided records lack clear documentation of recent urine drug test, risk assessment profile, attempt at weaning/tapering, and an updated and signed pain contract and ongoing efficacy with medication use. Regarding MRI of the cervical spine/thoracic spine/lumbar spine/left ankle, it is not clear that a new MRI was actually ordered. The clinical records do not indicate specific medical necessity to repeat any new MRIs. Regarding Biotouch IF unit, there was no evidence of failure of all the appropriate first-line treatments for ongoing pain. There is no reason as to why other modalities cannot be tried for treatment. Regarding cold unit, given the general lack of guideline support for continuous flow cold therapy, heat therapy, and/or contrast therapy for the cervical, lumbar, and thoracic spine as it applies to this patient's condition, it appears the use of a cold unit is not indicated. Regarding eight physical therapy sessions, the patient has completed at least 15 sessions of physical therapy in the past. However, there is no documentation of objective improvement with previous treatment, functional deficits, functional goals, and a statement identifying why an independent home exercise program would be insufficient to address any remaining functional deficits. Regarding internal medicine consultation, provider records do not indicate a clear rationale for the requested consultation. Regarding psychiatric consultation, there is no documented mental status examination and no documented depression associated with chronic pain issues. Regarding neurologist consultation, there was no clear medical rationale request to neurological consultation at this point. The physical examination lacked any focal neurological findings or deficits.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flurbi/Trama/Cyclo #210 gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, compounded. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 page Page(s): 25,28, 111-113.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that ketoprofen, lidocaine (in creams, lotion or gels), capsaicin in anything greater than a 0.025% formulation, baclofen, Boswellia Serrata Resin, and other muscle relaxants, and gabapentin and other

antiepilepsy drugs are not recommended for topical applications. In addition, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Guidelines do not support the use of flurbiprofen, tramadol, or cyclobenzaprine in a topical formulation. A specific rationale identifying why this topical compounded medication would be required in this patient despite lack of guideline support was not provided. Therefore, the request for Flurbi/Trama/ Cyclo 210 grams is not medically necessary or appropriate.

Gaba/Amit/Dextro #210 gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, compounded. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines 9792.24.2 page(s) Page(s): 25, 28 111-113.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that ketoprofen, lidocaine (in creams, lotion or gels), capsaicin in anything greater than a 0.025% formulation, baclofen, Boswellia Serrata Resin, and other muscle relaxants, and gabapentin and other antiepilepsy drugs are not recommended for topical applications. In addition, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Guidelines do not support the use of gabapentin, amitriptyline, or dextromethorphan in a topical formulation. A specific rationale identifying why this topical compounded medication would be required in this patient despite lack of guideline support was not provided. Therefore, the request for Gaba/ Amit/Dextro 210 grams is not medically necessary.

Terocin patches #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, compounded Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 112.

Decision rationale: The Chronic Pain Medical Treatment Guidelines states that topical lidocaine in the formulation of a dermal patch has been designated for orphans status by the FDA for neuropathic pain. In addition, the Chronic Pain Medical Treatment Guidelines states that topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). The guidelines state that the area for treatment should be designated as well as number of planned patches and duration for use (number of hours per day). For continued use, there should be documentation of a successful trial of Terocin patches, as well as a discussion of functional improvement, including the ability to decrease the patient's oral pain medications.

The documentation provided does not provide this information. In addition, there is no discussion in the reports regarding the patient failing treatment with a first-line agent such as gabapentin. Therefore, the request for Terocin patches thirty count is not medically necessary or appropriate.

Omeprazole 20 mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Proton Pump Inhibitors.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 68.

Decision rationale: The Medical Treatment Utilization Section (MTUS) and the FDA support proton pump inhibitors in the treatment of patients with GI disorders such as; gastric/duodenal ulcers, GERD, erosive esophagitis, or patients utilizing chronic NSAID therapy. Prilosec is a proton pump inhibitor, PPI (proton pump inhibitor), used in treating reflux esophagitis and peptic ulcer disease. There is no comment that relates the need for the proton pump inhibitor for treating gastric symptoms associated with the medications used in treating this industrial injury. In general, the use of a PPI should be limited to the recognized indications and used at the lowest dose for the shortest possible amount of time. It is documented that the patient is currently taking Naproxen. Guidelines support the prophylactic use of Omeprazole in patients utilizing chronic NSAID therapy. However, it is unclear how the patient is taking Omeprazole. Omeprazole is indicated for once daily dosing. This is a request for 60 tablets, and it is unclear if the patient is taking it once daily or twice daily. Therefore, the request for Omeprazole 20 mg sixty count is not medically necessary or appropriate.

Hydrocodone 2.5/325 mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 78-81.

Decision rationale: The Chronic Pain Medical Treatment Guidelines do not support ongoing opioid treatment unless prescriptions are from a single practitioner and are taken as directed; are prescribed at the lowest possible dose; and unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. A UR decision dated April 7, 2014 recommended weaning the patient off of Hydrocodone 2.5/325 mg. There is no documentation that the provider has addressed the issue of weaning. In the reports reviewed, there is no documentation of significant pain reduction or improved activities of daily living. Furthermore, there is no documentation of lack of aberrant behavior or adverse side effects, an opioid pain contract, urine drug screen, or CURES monitoring. Therefore, the request for Hydrocodone 2.5/325 mg ninety count is not medically necessary or appropriate.

MRI of the cervical spine, thoracic spine, lumbar spine, and left ankle: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 179-180 374 303-304, table 8. Decision based on Non-MTUS Citation Neck and Upper Back Chapter - MRI; Low Back Chapter - MRI.

Decision rationale: The Neck and Upper Back Complaints Chapter of the American College of Occupational and Environmental Medicine (ACOEM) Practice Guidelines supports imaging studies with red flag conditions; physiologic evidence of tissue insult or neurologic dysfunction; failure to progress in a strengthening program intended to avoid surgery; clarification of the anatomy prior to an invasive procedure and definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. In addition, ODG supports thoracic MRI studies in the setting of thoracic spine trauma with neurological deficit. The Neck and Upper Back Complaints Chapter of the ACOEM Practice Guidelines supports imaging of the lumbar spine in patients with red flag diagnoses where plain film radiographs are negative; unequivocal objective findings that identify specific nerve compromise on the neurologic examination, failure to respond to treatment, and consideration for surgery. CA MTUS states that disorders of soft tissue (such as tendinitis, metatarsalgia, fasciitis, and neuroma) yield negative radiographs and do not warrant other studies, e.g., magnetic resonance imaging (MRI). Magnetic resonance imaging may be helpful to clarify a diagnosis such as osteochondritis dissecans in cases of delayed recovery. In addition, ODG states that ankle MRI is indicated with chronic ankle pain, pain of uncertain etiology, plain films normal. There is documentation that the patient has had a previous cervical, thoracic, and ankle MRI done in March, 2014. According to the reports reviewed, there have been no significant changes in the patient's condition to substantiate another MRI at this time. In addition, there was no neurologic exam performed according to the reports reviewed. There was no documentation that the patient has failed conservative therapy options. Therefore, the request for an MRI of the cervical spine, thoracic spine, lumbar spine, and left ankle is not medically necessary or appropriate.

Biotouch IF (interferential) unit: 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 03/12/2013.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2 Page(s): 118-120.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that a one-month trial may be appropriate when pain is ineffectively controlled due to diminished effectiveness of medications; or pain is ineffectively controlled with medications due to side effects; or history of substance abuse; or significant pain from postoperative conditions limits the ability to perform;

exercise programs/physical therapy treatment; or unresponsive to conservative measures. There is no documentation that the patient has failed conservative treatment, such as medications and physical therapy. It is unclear why the patient requires an interferential unit at this time. Therefore, the request for Biotouch IF unit is not medically necessary or appropriate.

Cold unit: 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 03/12/2013.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Aetna Clinical Policy Bulletin: Cryoanalgesia and Therapeutic Cold.

Decision rationale: CA MTUS and ODG do not address this issue. Aetna considers the use of the Hot/Ice Machine and similar devices (e.g., the Hot/Ice Thermal Blanket, the TEC Thermoelectric Cooling System (an iceless cold compression device), the Vital Wear Cold/Hot Wrap, and the Vital Wrap) experimental and investigational for reducing pain and swelling after surgery or injury. Studies in the published literature have been poorly designed and have failed to show that the Hot/Ice Machine offers any benefit over standard cryotherapy with ice bags/packs; and there are no studies evaluating its use as a heat source. According to the reports reviewed, there is no documentation that the patient has tried and failed the use of ice packs. A specific rationale identifying why a cold unit would be required in this patient despite lack of guideline support was not provided. Therefore, the request for a cold unit was not medically necessary or appropriate.

Eight (8) physical therapy sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine. Decision based on Non-MTUS Citation ODG, Physical therapy.

MAXIMUS guideline: Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines 9792.24.2 9792.22 General Approaches Page(s): 98-99;. Decision based on Non-MTUS Citation Pain, Suffering, and the Restoration of Function Chapter 6 page 114 Physical Therapy Guidelines.

Decision rationale: The Chronic Pain Medical Treatment Guidelines stresses the importance of a time-limited treatment plan with clearly defined functional goals, frequent assessment and modification of the treatment plan based upon the patient's progress in meeting those goals, and monitoring from the treating physician regarding progress and continued benefit of treatment is paramount. Physical Medicine Guidelines - Allow for fading of treatment frequency. According to the reported dated March 5, 2014, the patient has already completed fifteen physical therapy sessions. There was no documentation of functional improvement or increased activities of daily living from the completed sessions. In addition, it is unclear why the patient has not transitioned to a home exercise program at this time. Furthermore, excessive physical therapy can lead the

physical therapy dependence. Therefore, the request for eight physical therapy sessions is not medically necessary or appropriate.

Internal medicine consultation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 127.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.23 Clinical Topics. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 6 127, 156.

Decision rationale: The Chronic Pain Medical Treatment Guidelines states that consultations are recommended, and a health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present or when the plan or course of care may benefit from additional expertise. In the reports reviewed, there was no documentation regarding an internal medicine consultation. It is unclear why the provider is requesting this consultation at this time. Therefore, the request for Internal medicine consultation was not medically necessary.

Psychiatric consultation: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 127.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 23 Clinical Topics. Decision based on Non-MTUS Citation Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 6 page(s) 127, 156.

Decision rationale: The Chronic Pain Medical Treatment Guidelines states that consultations are recommended, and a health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present or when the plan or course of care may benefit from additional expertise. According to a report dated March 5, 2014, the patient complained of anxiety, depression, insomnia, and nervousness. Guidelines support consultations as the primary treating physician feels is necessary. Therefore, the request for psychiatric consultation is medically necessary and appropriate.

Neurologist consultation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 127.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Clinical Topics. Decision based on Non-MTUS Citation ACOEM), 2nd Edition, (2004) Chapter 6 page(s) 127, 156.

Decision rationale: The Chronic Pain Medical Treatment Guidelines states that consultations are recommended, and a health practitioner may refer to other specialists if a diagnosis is

uncertain or extremely complex, when psychosocial factors are present or when the plan or course of care may benefit from additional expertise. In the reports reviewed, there is no documentation as to why the patient requires a neurological consultation. It is unclear why the provider is requesting this consultation at this time. Therefore, the request for a neurologist consultation is not medically necessary or appropriate.