

Case Number:	CM14-0198808		
Date Assigned:	12/09/2014	Date of Injury:	04/23/2014
Decision Date:	01/29/2015	UR Denial Date:	10/30/2014
Priority:	Standard	Application Received:	11/26/2014

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 Rehab, has a subspecialty in Interventional Spine 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 patient is a 52 year old male with an injury date of 04/23/14. Based on the 04/24/14 progress report, the patient complains of low back pain. The 05/02/14 report indicates that the patient has midline neck pain and discomfort, midline upper back pain and discomfort, and midline low back pain which radiates to his left thigh. He rates his back and neck pain as a 3/10. His thoracic back has a decreased range of motion and tenderness. His lumbar back has a decreased range of motion and tenderness as well. The 10/20/14 report states that the patient has a constant dull to frequent severe neck pain which radiates to the back of the head, upper back, down the mid back, and down the lower back. He also has frequent headaches. The patient has a right antalgic gait as well as tenderness along the midline paravertebral muscles. Tinel's sign is positive at the elbows. There is decreased sensation along the lateral bilaterally legs and lateral bilateral feet. The patient's diagnoses include the following: Cervicothoracic spine sprain Lumbar sprain with bilateral sciatica, r/o bilateral L5-S1 radiculopathy The utilization review determination being challenged is dated 10/30/14. Treatment reports were provided from 04/24/14, 05/02/14, and 10/20/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Acupuncture x12 cervical:

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

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

Decision rationale: The patient presents with low back pain, mid-line neck pain, and mid-line upper back pain. The request is for acupuncture x 12 cervical. For acupuncture, the MTUS Guidelines page 8 recommends acupuncture for pain, suffering, and for restoration of function. Recommended frequency and duration is 3 to 6 treatments for trial, and with functional improvement, 1 to 2 per month. For additional treatment, the MTUS Guidelines requires functional improvement as defined by Labor Code 9792.20(e) a significant improvement in ADLs, or change in work status and reduced dependence on medical treatments. In this case, there is no indication that the patient has had any prior acupuncture sessions for the cervical spine. It may be reasonable to provide an initial trial of 3 to 6 treatments to produce functional improvement, as required by MTUS guidelines. However, the treating physician is requesting for a total of 12 sessions of acupuncture which exceeds what the guidelines recommend for an initial trial. The requested 12 sessions of acupuncture for the cervical spine is not medically necessary.

Initial FCE: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, Chapter 7, pg 132-139

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7 page 137, FCE

Decision rationale: The patient presents with low back pain, mid-line neck pain, and mid-line upper back pain. The request is for an Initial Functional Capacity Evaluation. MTUS does not discuss functional capacity evaluations. Regarding Functional/Capacity Evaluation, ACOEM Guidelines Chapter 7 page 137 states, "The examiner is responsible for determining whether the impairment results in functional limitations. The employer or claim administrator may request functional ability evaluations. These assessments also may be ordered by the treating or evaluating physician, if the physician feels the information from such testing is crucial. There is little scientific evidence confirming that FCEs predict an individual's actual capacity to perform in the workplace." There is no discussion provided on the patient's work status and it is unknown if the request was from the employer or the treater. ACOEM supports FCE if asked by the administrator, employer, or if it is deemed crucial. In this case, there is no discussion provided on the requested functional capacity evaluation and the treater does not explain why FCE is crucial. Per ACOEM, there is lack of evidence that FCEs predict the patient's actual capacity to work. The requested Functional Capacity Evaluation is not medically necessary.

Gaba-Keto-Lido Cream: 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.

Decision rationale: The patient presents with low back pain, mid-line neck pain, and mid-line upper back pain. The request is for compound medication: Gaba-Keto-Lido cream. The MTUS guidelines page 111 on topical analgesics states that it is largely experimental in use with few randomized controlled trials to determine efficacy or safety. It is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. MTUS further states, "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." MTUS page 111 states "Non FDA-approved agents: Ketoprofen: This agent is not currently FDA approved for a topical application. It has an extremely high incidence of photo-contact dermatitis." Per MTUS, gabapentin is not recommended in any topical formulation. MTUS guidelines do not allow any other formulation of Lidocaine other than in patch form. In this case, guidelines do not recommend a compounded product if one of the compounds are not indicated for use. Gabapentin, Ketoprofen, nor Lidocaine (in a non-patch form) are indicated for use as a topical formulation. Therefore, the requested topical medication: Gaba- Keto- Lido Cream is not medically necessary.

IF Unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

Decision rationale: The patient presents with low back pain, mid-line neck pain, and mid-line upper back pain. The request is for an IF UNIT. For Interferential Current Stimulation (ICS), MTUS guidelines, pages 118 - 120, state that "Not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone." These devices are recommended in cases where (1) Pain is ineffectively controlled due to diminished effectiveness of medications; or (2) Pain is ineffectively controlled with medications due to side effects; or (3) History of substance abuse; or (4) Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or (5) Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). The reason for the request was not provided. The 05/02/14 report indicates that the patient is currently taking Hydrocodone- Acetaminophen. The treater does not document side effects due to medication. Review of progress reports does not show documentation of patient's history of substance abuse, operative condition, nor unresponsiveness to conservative measures. Documentation to support MTUS criteria has not been met. Furthermore, MTUS require 30-day trial of the unit showing pain and functional benefit before a home unit is allowed. In this case, there was no 30 day trial with the interferential unit. Therefore, the requested IF unit is not medically necessary.