

<b>Case Number:</b>	CM14-0207680		
<b>Date Assigned:</b>	02/02/2015	<b>Date of Injury:</b>	10/27/2013
<b>Decision Date:</b>	04/21/2015	<b>UR Denial Date:</b>	12/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/11/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: New York  
 Certification(s)/Specialty: Emergency Medicine

### 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 25 year old male has reported the gradual onset of multifocal pain and mental illness attributed to usual work activity, with a listed injury date of 10/27/2013. The current diagnoses include headache, cervical strain/sprain, lumbosacral strain, thoracic strain, right knee strain/sprain, status post right knee ACL repair in 2004, depression, sleep disturbance secondary to pain, and blurred vision. According to the medical reports, the injured worker was terminated from his job and is not working. According to a Doctor's First Report of Occupational Injury dated 11/13/2014, there were headaches, neck, back, and right knee pain, left eye blurred vision, depression/anxiety and insomnia. Physical findings included tenderness, spasm decreased range of motion, right knee healed arthroscopy portals and a linear incision, knee crepitus, and a positive patellar apprehension test. The work status was "temporarily totally disabled." The treatment plan included the items now under Independent Medical Review and those items certified in Utilization Review. The functional capacity evaluation was stated to "ensure the patient can safely meet the physical demands of their occupation." There was no specific rationale for the remainder of the treatment plan. The medical report did not provide the dates of onset for the various symptomatic areas, specific signs and symptoms to indicate the need for any testing, and any details of prior treatment, including the reference to self-medication. On 12/01/2014 Utilization Review non-certified physical therapy for the right knee and cervical/thoracic/lumbar spine, physical performance Functional Capacity Evaluation, x-ray of the right knee, x-ray of the lumbar spine, hot & cold unit, Fluriflex 180 grams, TG Hot 180 grams, and Cyclobenzaprine 7.5mg #60. The MTUS and the Official Disability Guidelines were

cited. UR certified consultations with a psychologist and ophthalmology, radiographs of the cervical spine, and Motrin #60.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Physical therapy evaluation and treatment for the right knee, 2x4 weeks: 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).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Introduction, functional improvement; Physical Medicine Page(s): 9, 98-99.

**Decision rationale:** The treating physician has not provided an adequate prescription, which must contain diagnosis, duration, frequency, and treatment modalities, at a minimum. The treating physician did not provide sufficient details of the history of any knee condition, including duration and type of symptoms or functional deficits. Per the MTUS, Chronic Pain section, functional improvement is the goal rather than the elimination of pain. The treating physician has not stated a purpose for the current physical therapy prescription. It is not clear what is intended to be accomplished with this physical therapy, given that it will not cure chronic pain and there are no other goals of therapy. Given the completely non-specific prescription for physical therapy in this case, it is presumed that the therapy will use passive modalities. The MTUS recommends against passive modalities for chronic pain. Total disability work status implies a likely lack of ability to attend physical therapy, as the injured worker is incapable of performing any and all work activity, even very light activity such as sitting, standing, and walking. "Temporarily totally disabled" status is not an appropriate baseline for initiation of a physical therapy program emphasizing functional improvement. The prescription for Physical Medicine is not medically necessary based on the MTUS recommendations, lack of sufficient emphasis on functional improvement, lack of a sufficient prescription, and lack of sufficient clinical evaluation.

#### **Physical therapy evaluation and treatment of the cervical/thoracic/lumbar spine, 2x4weeks: 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).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Introduction, functional improvement; Physical Medicine Page(s): 9, 98-99.

**Decision rationale:** The treating physician has not provided an adequate prescription, which must contain diagnosis, duration, frequency, and treatment modalities, at a minimum. The treating physician did not provide sufficient details of the history of any spine condition, including duration and type of symptoms and functional deficits. Per the MTUS, Chronic Pain section, functional improvement is the goal rather than the elimination of pain. The treating

physician has not stated a purpose for the current physical therapy prescription. It is not clear what is intended to be accomplished with this physical therapy, given that it will not cure chronic pain and there are no other goals of therapy. Given the completely non-specific prescription for physical therapy in this case, it is presumed that the therapy will use passive modalities. The MTUS recommends against passive modalities for chronic pain. Total disability work status implies a likely lack of ability to attend physical therapy, as the injured worker is incapable of performing any and all work activity, even very light activity such as sitting, standing, and walking. "Temporarily totally disabled" status is not an appropriate baseline for initiation of a physical therapy program emphasizing functional improvement. The prescription for Physical Medicine is not medically necessary based on the MTUS recommendations, lack of sufficient emphasis on functional improvement, lack of a sufficient prescription, and lack of sufficient clinical evaluation.

**Physical performance FCE: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 48.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 81. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter 7, Pages 137-8, discussion of IME recommendations (includes functional capacity evaluation). Fitness for Duty chapter, Functional capacity evaluation.

**Decision rationale:** The ACOEM guidelines pages 137-8, in the section referring to Independent Medical Evaluations (which is not the context in this case), state "there is little scientific evidence confirming that functional capacity evaluations predict an individual's actual capacity to perform in the workplace" and "...it is problematic to rely solely upon the functional capacity evaluation results for determination of current work capability and restrictions." The MTUS for Chronic Pain and the Official Disability Guidelines recommend a functional capacity evaluation for Work Hardening programs, which is not the context in this case. The Official Disability Guidelines state that a functional capacity evaluation is "Recommended prior to admission to a Work Hardening (WH) Program, with preference for assessments tailored to a specific task or job. Not recommend routine use as part of occupational rehab or screening, or generic assessments in which the question is whether someone can do any type of job generally." The current request does not meet this recommendation as it appears to be intended for general rather than job-specific use. The treating physician did not discuss the fact that this injured worker was terminated from his job and that there did not appear to be any job to which he was returning. The treating physician has not defined the components of the functional capacity evaluation. Given that there is no formal definition of a functional capacity evaluation, and that a functional capacity evaluation might refer to a vast array of tests and procedures, medical necessity for a functional capacity evaluation (assuming that any exists), cannot be determined without a specific prescription which includes a description of the intended content of the evaluation. The MTUS for Chronic Pain, in the Work Conditioning-Work Hardening section, mentions a functional capacity evaluation as a possible criterion for entry, based on specific job demands. The treating physician has not provided any information in compliance with this portion of the

MTUS. The functional capacity evaluation in this case is not medically necessary based on lack of medical necessity and lack of a sufficiently specific prescription.

**X-ray of the right knee:** 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), Knee Chapter.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 332-335, 341, 343, 344-345, 347.

**Decision rationale:** Per the ACOEM Guidelines Page 341, special studies are not needed to evaluate most knee conditions until after a period of conservative care and observation. Page 343 lists surgical indications: activity limitation for more than one month, failure of an exercise program. Pages 344-5 discuss focal pathology amenable to surgery. Page 347 lists the clinical findings, which indicate the need for surgery. In this case, the question would be whether there is a realistic possibility of significant intra-articular pathology and need for surgery after a failure of conservative care. The available reports do not adequately explain the kinds of conservative care already performed. The necessary components of the knee exam are not present, see pages 332-335 of the ACOEM Guidelines. There is no evidence of a period of conservative care prior to prescribing the radiographs, and the necessary components of the examination are not provided. The treating physician has not provided the specific indications for the radiographs. The radiographs are not medically necessary based on the MTUS and lack of specific indications.

**X-ray of the lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303 - 304, table 12-8. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303, 290. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back chapter, Radiography (x-rays).

**Decision rationale:** The treating physician has not described the clinical evidence of significant pathology discussed in the MTUS, such as "Unequivocal objective findings that identify specific nerve compromise on the neurologic examination." No "red flag" conditions are identified. The treating physician has not provided an adequate clinical evaluation, as outlined in the MTUS ACOEM Guidelines Pages 291-296. The treating physician has not provided specific indications for the radiographs. Per the Official Disability Guidelines citation above, imaging for low back pain is not beneficial in the absence of specific signs of serious pathology. Radiographs of the lumbar spine are not medically necessary based on lack of sufficient indications per the MTUS and the Official Disability Guidelines.

**Hot & Cold unit:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation online resource PubMed, indexed for Medline.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment, Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 48,299-300, 308,174. Decision based on Non-MTUS Citation ACOEM Guidelines, Updated Chronic Pain Section, Page 166, 168; heat and cold therapies.

**Decision rationale:** The MTUS for Chronic Pain does not provide direction for the use of heat or cold to treat chronic pain. The ACOEM Guidelines pages 299-300 recommend application of heat or cold for low back pain. At-home applications of heat or cold are as effective as those performed by therapists. Page 308 recommends home application of heat or cold. The ACOEM Guidelines page 174 recommends cold packs during the first few days for neck pain, and heat thereafter. There is no recommendation for any specific device in order to accomplish this. Heat and cold can be applied to the skin using simple home materials, e.g. ice and hot water, without any formal medical device or equipment. Per Page 48 of the Guidelines, heat or cold may be used for two weeks or less. This patient's condition is long past the two-week duration. The updated ACOEM Guidelines for Chronic Pain are also cited. There may be some indication for heat or cold therapy, but the recommendation is for home application of non-proprietary, low-tech, heat therapy in the context of functional restoration. There is no evidence of any current functional restoration program. The treating physician has not provided any information in support of the specific devices prescribed for this patient. The cold-heat device prescribed for this injured worker is not medically necessary based on the MTUS, other guidelines, and lack of a sufficient treatment plan.

**Fluriflex 180 grams:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain; Topical Medications Page(s): 60,111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, Topical analgesics.

**Decision rationale:** No physician reports discuss the specific indications and medical evidence in support of the topical medications prescribed in this case. The ingredients appear to include Flurbiprofen/Cyclobenzaprine. The treating physician has not discussed the ingredients of this topical agent and the specific indications for this injured worker. Per the MTUS page 60, medications are to be given individually, one at a time, with assessment of specific benefit for each medication. Provision of multiple medications simultaneously is not recommended. In addition to any other reason for lack of medical necessity for these topical agents, they are not medically necessary on this basis at minimum. The Official Disability Guidelines state that "Custom compounding and dispensing of combinations of medicines that have never been studied is not recommended, as there is no evidence to support their use and there is potential for

harm." The compounded topical agent in this case is not supported by good medical evidence and is not medically necessary based on this Official Disability Guidelines recommendation. The MTUS states that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Per the MTUS citation, there is no good evidence in support of topical muscle relaxants; these agents are not recommended. Two muscle relaxants were dispensed simultaneously, which is duplicative, unnecessary, and potentially toxic. Per the MTUS, topical NSAIDs for short-term pain relief may be indicated for pain in the extremities caused by osteoarthritis or tendonitis. There is no good evidence supporting topical NSAIDs for axial pain. This injured worker is already taking an oral NSAID, making a topical NSAID duplicative and unnecessary, as well as possibly toxic. The treating physician did not provide any indications or body part intended for this NSAID. Note that topical flurbiprofen is not FDA approved, and is therefore experimental and cannot be presumed as safe and efficacious. Non-FDA approved medications are not medically necessary. The topical compounded medication prescribed for this injured worker is not medically necessary based on the MTUS, the Official Disability Guidelines, lack of medical evidence, and lack of FDA approval.

**TG Hot 180 grams:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain; Topical Medications Page(s): 60,111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, Topical analgesics.

**Decision rationale:** No physician reports discuss the specific indications and medical evidence in support of the topical medications prescribed in this case. The ingredients appear to include tramadol-gabapentin-menthol-camphor-capsaicin. The treating physician has not discussed the ingredients of this topical agent and the specific indications for this injured worker. Per the MTUS page 60, medications are to be given individually, one at a time, with assessment of specific benefit for each medication. Provision of multiple medications simultaneously is not recommended. In addition to any other reason for lack of medical necessity for these topical agents, they are not medically necessary on this basis at minimum. The Official Disability Guidelines state that "Custom compounding and dispensing of combinations of medicines that have never been studied is not recommended, as there is no evidence to support their use and there is potential for harm." The compounded topical agent in this case is not supported by good medical evidence and is not medically necessary based on this Official Disability Guidelines recommendation. The MTUS states that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Per the MTUS citation, there is no good evidence in support of topical gabapentin; this agent is not recommended. Capsaicin has some indications, in the standard formulations readily available without custom compounding. It is not clear what the indication is in this case, as the injured worker does not appear to have the necessary indications per the MTUS. The MTUS also states that capsaicin is only recommended when other treatments have failed. This injured worker has not received adequate trials of other, more conventional treatments. The treating physician did not discuss the failure of other, adequate trials of other treatments. Capsaicin is not medically necessary based on the lack of

indications per the MTUS. There is no good evidence supporting topical tramadol. Menthol and camphor are not discussed specifically in the MTUS. The topical compounded medication prescribed for this injured worker is not medically necessary based on the MTUS, the Official Disability Guidelines, and lack of medical evidence.

**Cyclobenzaprine 7.5mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Muscle relaxants.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines muscle relaxants Page(s): 63.

**Decision rationale:** The MTUS for Chronic Pain does not recommend muscle relaxants for chronic pain. Non-sedating muscle relaxants are an option for short-term exacerbations of chronic low back pain. The muscle relaxant prescribed in this case is sedating. This injured worker has chronic pain with no evidence of prescribing for flare-ups. The quantity prescribed implies long-term use, not a short period of use for acute pain. Cyclobenzaprine, per the MTUS, is indicated for short-term use only and is not recommended in combination with other agents. This injured worker has been prescribed multiple medications along with cyclobenzaprine. A topical cyclobenzaprine was also prescribed, which is redundant and possibly toxic. Per the MTUS, this muscle relaxant is not indicated and is not medically necessary.