

Case Number:	CM15-0004010		
Date Assigned:	01/15/2015	Date of Injury:	09/27/2014
Decision Date:	03/24/2015	UR Denial Date:	12/23/2014
Priority:	Standard	Application Received:	01/08/2015

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: California, Washington

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 female who reported an injury on 09/27/2014. The mechanism of injury was the injured worker lifted a patient alone, and it was noted the particular patient required 2 workers to lift and move. The patient was noted to be 6 feet tall and weighed approximately 300 pounds. The patient took 2 steps to the commode, but the patient's legs gave way and the injured worker attempted to keep the patient from falling. The diagnostic studies were not provided. Prior treatments included a chair back support and a lumbar support. The diagnoses included lumbosacral sprain and strain with right sciatica, rule out L5 radiculopathy, and rule out insomnia. The documentation of 12/08/2014, revealed the injured worker had lumbar spine aching pain, with radiation of pain to the right lower extremity. The injured worker had had associated numbness and tingling in the lower extremity. The injured worker had instability and gait disturbance due to the numbness and tingling. The documentation indicated the injured worker had 2 falls. The physician indicated he would order a cane to avoid the falls. There was noted to be an order for an EMG/NCS to rule out neuropathy or radiculopathy. There was no change in the functional evaluation. The treatment plan included the injured worker was cleared for physical therapy. The injured worker should have x-rays of the lumbar spine, acupuncture, physical therapy, EMG/NCV of the bilateral lower extremities, and a pain management visit as well as a visit with a psychiatrist or psychologist. The medication included tramadol 50 mg, 1 by mouth twice a day as needed pain. There was no request for authorization submitted for review. Additionally, the documentation requested Naprosyn topical cream, an

interferential unit, and a Functional Capacity Evaluation for lumbar spine range of motion. There was no Request for Authorization submitted to support the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy initial functional capacity evaluation, lower back: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Chapter 7: Independent Medical Examinations and Consultations page 137-138

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness for Duty Chapter, FCE.

Decision rationale: The American College of Occupational and Environmental Medicine guidelines indicate there is a functional assessment tool available and that is a Functional Capacity Evaluation, however, it does not address the criteria. As such, secondary guidelines were sought. The Official Disability Guidelines indicates that a Functional Capacity Evaluation is appropriate when a worker has had prior unsuccessful attempts to return to work, has conflicting medical reports, the patient had an injury that required a detailed exploration of a workers abilities, a worker is close to maximum medical improvement and/or additional or secondary conditions have been clarified. The physician documentation indicated there was a baseline Functional Capacity Evaluation necessary to assess the activities of daily living at the start of treatment. However, they do not specifically address the injured worker had a failure to return to work and there was a necessity for a detailed exploration of the injured worker's abilities, or that the injured worker was close to maximum medical improvement and that additional secondary conditions had been clarified. Given the above, the request for physical therapy initial Functional Capacity Evaluation, lower back, is not medically necessary.

Topical Naprosyn topical cream: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Topical NSAIDS Page(s): 111-112.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines indicates that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The guidelines also indicate that Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period. When investigated specifically for osteoarthritis

of the knee, topical NSAIDs have been shown to be superior to placebo for 4 to 12 weeks. These medications may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. Indications: Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic pain: Not recommended as there is no evidence to support use. The clinical documentation submitted for review failed to indicate the injured worker had a trial and failure of antidepressants and anticonvulsants. There was a lack of documentation indicating the body part to be treated, the quantity, and frequency for the requested medication. Given the above, and the lack of documentation, the request for topical Naprosyn topical cream is not medically necessary.

IF Unit for the low back: Upheld

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

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

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines do not recommend interferential current stimulation as an isolated intervention. There was no quality evidence of the effectiveness, except in conjunction with recommended treatments, including return to work, exercise, and medications. The clinical documentation submitted for review indicated the injured worker was being recommended for physical therapy. However, there was a lack of documentation indicating the injured worker would be utilizing the unit with therapy. The request as submitted failed to indicate whether the unit was for rental for purchase. Given the above, the request for IF unit for the low back is not medically necessary.

Consultation with a pain management for management of pain medication for lower back: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Chapter 7: Independent Medical Examinations and Consultations page 127

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ongoing management Page(s): 78.

Decision rationale: The California MTUS guidelines recommend consideration of a consultation with a multidisciplinary pain clinic if doses of opioids are required beyond what is usually required for the condition or pain does not improve on opioids in 3 months. The clinical documentation submitted for review failed to indicate the injured worker had been utilizing opioids for 3 months. There was a lack of documentation of prior therapy to support the necessity for consultation for pain management. Given the above, the request for consultation

with pain management for management of pain medication for lower back is not medically necessary.

Physical therapy 2 times a week for 3 weeks for lower back: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines

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

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend physical medicine treatment for myalgia and myositis for up to 10 visits. There was a lack of documentation of objective findings and documentation of objective functional deficits to support the necessity for physical medicine treatment. Given the above, the request for physical therapy, 2 times a week for 3 weeks for low back, is not medically necessary. Additionally, there was a lack of documentation indicating the prior therapies that had been utilized.