

Case Number:	CM15-0103006		
Date Assigned:	06/08/2015	Date of Injury:	09/15/2013
Decision Date:	07/10/2015	UR Denial Date:	05/08/2015
Priority:	Standard	Application Received:	05/28/2015

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: New York
 Certification(s)/Specialty: Anesthesiology

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 21-year-old male who sustained an industrial injury on 09/15/2013. Current diagnoses include head pain, lumbosacral musculoligamentous strain/sprain with radiculopathy, rule out lumbosacral spine discogenic disease, bilateral shoulder strain/sprain, rule out bilateral shoulder impingement syndrome, and lumbar spine radiculopathy radiating to lower extremities. Previous treatments included medications. Previous diagnostic studies include urine toxicology screening. Initial injuries sustained included the neck, bilateral shoulders, low back, bilateral knees, and bilateral ankles/feet when he bent over to pick up several racks from the floor. Report dated 04/29/2015 noted that the injured worker presented with complaints that included headaches, back pain, bilateral shoulder pain, bilateral leg pain, and bilateral foot pain. Pain level was not included. Physical examination was positive for abnormalities in the thoracic spine, lumbar spine, bilateral shoulders, and bilateral lower extremity. The treatment plan included prescribing oral and topical medications, lumbosacral brace, interferential unit, hot and cold unit, requests for an MRI, EMG/NCV study, physical therapy, functional capacity evaluation, and patient education web classes. Disputed treatments include a MRI of the lumbosacral spine, EMG/NCV study of the bilateral upper extremity, tramadol, Fexmid, flurbiprofen cream LA, gabapentin cream, interferential unit, hot and cold unit, functional capacity evaluation, patient education web classes, physical therapy, and lumbosacral brace.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI - lumbosacral spine: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MRI LS spine Page(s): 304.

Decision rationale: According to California MTUS Guidelines, MRI of the lumbosacral (LS) spine is recommended to evaluate for evidence of cauda equina, tumor, infection, radiculopathy after at least 1 month of conservative therapy, or fracture when plain films are negative and neurologic abnormalities are present on physical exam. In this case, there is documentation of subjective and objective findings of radiculopathy. Conservative treatment included medications and physical therapy. Medical necessity for the requested MRI has been established. The requested imaging study is medically necessary.

EMG/NCV - bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 303.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) EMG and NCV studies.

Decision rationale: There is no documentation provided necessitating EMG testing of both lower extremities. According to the ODG, EMG (Electromyography) and nerve conduction studies are an extension of the physical examination. They can be useful in adding in the diagnosis of peripheral nerve and muscle problems. This can include neuropathies, entrapment neuropathies, radiculopathies, and muscle disorders. According to ACOEM Guidelines, needle EMG and H-reflex tests to clarify nerve root dysfunction are recommended for the treatment of low back disorders. In this case, there is documentation of subjective and objective findings of radiculopathy. Given the documentation of the associated request, and medical necessity, for MRI of the LS spine, the EMG/NCV of the lower extremities is not warranted at this time. Medical necessity for the requested item has not been established. The requested studies are not medically necessary.

Tramadol 50 mg. #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91-97. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Opioids.

Decision rationale: According to the California MTUS, Tramadol (Ultram) is a synthetic opioid, which affects the central nervous system and is indicated for the treatment of moderate to severe pain. Per CA MTUS Guidelines, certain criteria need to be followed, including an ongoing review and documentation of pain relief and functional status, appropriate medication use, and side effects. Pain assessment should include current pain: last reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid, and the duration of pain relief. According to the medical records, there has been no documentation of the medication's analgesic effectiveness or functional improvement, and no clear documentation that the patient has responded to ongoing opioid therapy. In this case, it is not clear what other medications/ opiates have been tried. Tramadol is not recommended as a first-line oral analgesic. Medical necessity of the requested medication has not been established. Of note, discontinuation of an opioid analgesic requires a taper to avoid withdrawal symptoms. The requested medication is not medically necessary.

Fexmid 7.5 mg. #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants.

Decision rationale: Fexmid (Cyclobenzaprine) is a skeletal muscle relaxant and a central nervous system (CNS) depressant. According to the reviewed literature, Fexmid is not recommended for the long-term treatment of chronic pain. The medication has its greatest effect in the first four days of treatment and it is not recommended for longer than 2-3 weeks. According to the CA MTUS Guidelines, muscle relaxants are not considered any more effective than non-steroidal anti-inflammatory medications alone. In this case, there are muscle spasms documented on physical exam. However, the available records do not show a clearly documented benefit or any functional improvement from prior Fexmid use. In addition, there is no clinical indication presented for the chronic or indefinite use of this medication. Based on the currently available information, the medical necessity for this muscle relaxant medication has not been established. The requested treatment is not medically necessary.

Flurbiprofen cream LA (Flurbiprofen 20%, Lidocaine 5%, Amitriptyline 5%) 180 gms: 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: According to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, muscle relaxants, local anesthetics or antidepressants. Guidelines indicate that any compounded product that contains at least 1 non-recommended drug

(or drug class) is not recommended for use. In this case, the compounded cream contains: Flurbiprofen 20%, Lidocaine 5%, and Amitriptyline 5%. Flurbiprofen, used as a topical NSAID, has been shown in a meta-analysis to be superior to placebo during the first two weeks of treatment for osteoarthritis but either, not afterward, or with diminishing effect over another two-week period. There are no clinical studies to support the safety or effectiveness of Flurbiprofen in a topical delivery system (excluding ophthalmic). Medical necessity for the requested topical cream has not been established. The requested treatment is not medically necessary.

Gabacyclotram cream (Gabapentin 10%, Cyclobenzaprine 6%, Tramadol 10%) 180 gms:
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: According to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, muscle relaxants, local anesthetics or antidepressants. Guidelines indicate that any compounded product that contains at least 1 non-recommended drug (or drug class) is not recommended for use. In this case, the requested compounded topical agent is Gabapentin, Cyclobenzaprine, Tramadol (GabaCycloTram) cream. Cyclobenzaprine is not FDA approved for use as a topical application. There is no evidence for the use of any muscle relaxant as a topical agent. In addition, Gabapentin and Tramadol are not FDA approved for a topical application. There is no peer-reviewed literature to support its use. Medical necessity for the requested compounded topical analgesic cream has not been established. The request for the compounded topical analgesic agent is not medically necessary.

Interferential unit: 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 (ICS). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Interferential Current Stimulation (ICS).

Decision rationale: According to MTUS, Interferential Current Stimulation (ICS) is 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. There are no standardized protocols for the use of interferential therapy; and the therapy may vary according to the frequency of stimulation, the pulse duration, treatment time, and electrode-placement technique. The process involves paired electrodes of two independent circuits carry differing medium frequency alternating currents so that current flowing between each pair intersects at the underlying target. The frequency allows the Interferential wave to meet low impedance when crossing the skin. Treatments involve the use of two pairs of electrodes and most units allow

variation in waveform, stimulus frequency and amplitude or intensity, and the currents rise and fall at different frequencies. Evidence based guidelines do not support ICS in the management of the cited injuries in this case. The requested unit is not indicated at this time. Medical necessity for the requested unit has not been established. The requested unit is not medically necessary.

Hot and cold unit: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medscape Internal Medicine.

Decision rationale: After review of the literature, the home application of hot/cold packs is just as effective as those performed by a therapist. If cold therapy is desired, cold packs are readily available. There is no specific indication for a 30-day hot or cold therapy unit. A hot/cold therapy unit is not-supported for the management of this patient's cited injuries/condition. Medical necessity for the requested treatment has not been established. The requested treatment is not medically necessary.

Functional capacity evaluation: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional capacity evaluation (FCE) Page(s): 48. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Functional capacity evaluation.

Decision rationale: The CA MTUS states that a functional capacity evaluation (FCE) is recommended under certain specific circumstances. The importance of an assessment is to have a measure that can be used repeatedly over the course of treatment to demonstrate improvement of function, or maintenance of function that would otherwise deteriorate. It should include work functions and or activities of daily living, self-report of disability, objective measures of the patient's functional performance and physical impairments. The guidelines necessitate documentation indicating case management is hampered by complex issues (prior unsuccessful return to work attempts, conflicting medical reports on precautions and/or fitness for modified job), injuries that require detailed exploration of a worker's abilities, and clarification of all additional/secondary conditions in order to recommend an FCE. In this case, there is no documentation that any of the above conditions are present, which would be required to complete an FCE. There are no specific indications for an FCE. Medical necessity for the requested service has not been established. The requested service is not medically necessary.

Patient education web classes: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Education.

Decision rationale: According to the ODG, on-going education of the patient and family, as well as the employer, insurer, policy makers and the community should be the primary emphasis in the treatment of chronic pain. Currently, practitioners often think of education last, after medications, manual therapy and surgery. Practitioners must develop and implement an effective strategy and skills to educate patients, employers, insurance systems, policy makers and the community as a whole. An education-based paradigm should always start with inexpensive communication providing reassuring information to the patient. More in-depth education currently exists within a treatment regime employing functional restorative and innovative programs of prevention and rehabilitation. No treatment plan is complete without addressing issues of individual and/or group patient education as a means of facilitating self-management of symptoms and prevention. Within the medical information available for review, there is no documentation that the request of patient-education web classes represents medical treatment that should be reviewed for medical necessity. Medical necessity for the requested service has not been established. The requested education classes are not medically necessary.

Physical therapy - evaluation and 3 visits weekly for 4 weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical Therapy.

Decision rationale: According to the California MTUS Treatment guidelines, physical therapy (PT) is indicated for the treatment of musculoskeletal pain. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Per ODG, patients should be formally assessed after a "6-visit trial" to see progress made by patient. When the duration and/or number of visits have exceeded the guidelines, exceptional factors should be documented. Additional treatment would be assessed based on functional improvement and appropriate goals for additional treatment. In this case, there is documentation of previous PT visits. However, there is no documentation of the number of previous visits and if the number of sessions have already exceeded PT guidelines. In addition, there is no documentation indicating that he had a defined functional improvement in his condition. There is no specific indication for the additional 12 PT (3X4) sessions requested, which exceed the MTUS and ODG guidelines. Medical necessity for the additional PT visits requested has not been established. The requested services are not medically necessary.

Lumbosacral brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chapter 1 Prevention Page(s): 9, 308.

Decision rationale: According to the ACOEM guidelines, lumbar binders, corsets, or support belts are not recommended as treatment for low back pain. The guidelines state that the use of back belts as lumbar support should be avoided because they have been shown to have little or no benefit, thereby providing only a false sense of security. In addition, the guidelines do not recommend lumbar braces for treatment of low back pain. Medical necessity for this item has not been established. Therefore, the lumbar brace is not medically necessary.