

Case Number:	CM15-0105237		
Date Assigned:	06/09/2015	Date of Injury:	03/20/2015
Decision Date:	07/13/2015	UR Denial Date:	05/08/2015
Priority:	Standard	Application Received:	06/01/2015

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: Internal 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:

The injured worker is a 26 year old male who sustained an industrial injury on 3/20/15. The injured worker was diagnosed as having contact with potentially hazardous substance. Currently, the injured worker was with complaints of a puncture wound. Previous treatments included a medication management. Physical examination was notable for skin without evidence of exposure through an open skin wound, no evidence of rash or dermatitis, no ecchymosis or signs of infection or contamination. The plan of care was for physical therapy, functional capacity evaluation and medication prescriptions.

IMR ISSUES, DECISIONS AND RATIONALES

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

Fexmid 7.5mg quantity 90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Non Sedating Muscle Relaxants Page(s): 64-66.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain) Page(s): 63.

Decision rationale: Fexmid (Cyclobenzaprine) is a skeletal muscle relaxant and a central nervous system depressant recommended as a treatment option to decrease muscle spasm in conditions such as low back pain. Per MTUS guidelines, muscle relaxants are recommended for use with caution as a second-line option for only short-term treatment of acute exacerbations in patients with chronic low back pain. The greatest effect appears to be in the first 4 days of treatment and appears to diminish over time. Prolonged use can lead to dependence. The injured worker complains of pain in the right arm, right shoulder, right knee and leg. Documentation fails to show objective findings of muscle spasm or other symptoms that would establish the medical necessity for the use of a muscle relaxant. The request for Fexmid 7.5mg quantity 90 is not medically necessary per MTUS guidelines.

Flurbi Cream (flurbiprofen 20%, Lidocaine 5%, Amitriptyline 5%) 180gms: 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 Topical Analgesics Page(s): 111.

Decision rationale: MTUS states that use of topical analgesics is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many of these agents. Flurbiprofen is not FDA approved for topical application. Non-dermal patch formulations of Lidocaine such as creams, lotions and gels, are not indicated for treatment of neuropathic pain. These medications are used as local anesthetics and anti-pruritics. Per guidelines, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The request for Flurbi Cream (flurbiprofen 20%, Lidocaine 5%, Amitriptyline 5%) 180gms is not medically necessary by MTUS.

Interferential Unit, indefinite use: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 114-121.

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

Decision rationale: MTUS states that Interferential Current Stimulation is not recommended as isolated modality. There is very little evidence to show it is superior to standard Transcutaneous Electrical Nerve Stimulation (TENS). Electrotherapy is recommended in conjunction with other treatments, including return to work, exercise and medications. This form of treatment is appropriate for patients with significant pain from postoperative conditions that limit the ability to perform exercise programs/physical therapy treatment, or refractory to conservative measures (e.g., repositioning, heat/ice, etc.), patients whose pain is ineffectively controlled due to diminished effectiveness or side effects of medications or patients with history of substance abuse. If those criteria are met, then a one-month trial may be appropriate to permit the physician

and physical medicine provider to study the effects and benefits. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction. Documentation provided does not support that the injured worker is physically limited from a postoperative condition or participating in other recommended treatments, including a home exercise program. With MTUS criteria not being met, the medical necessity for an interferential unit has not been established. Subsequently, the request for Interferential Unit, indefinite use is not medically necessary.

Physical Performance - Functional Capacity Evaluation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 137-138.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional restoration programs (FRPs) Page(s): 49. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Programs.

Decision rationale: Per guidelines, Functional Restorative Programs were designed to use a medically directed, interdisciplinary pain management approach geared specifically to patients with chronic disabling occupational musculoskeletal disorders. They are recommended for patients with conditions that have resulted in delayed recovery. Chart documentation does not support that the injured worker's condition is chronic or that maximum medical therapy has been reached. With MTUS guidelines not being met, the request for Physical Performance - Functional Capacity Evaluation is not medically necessary.

Physical therapy, 12 sessions: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98 - 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Shoulder Chapters, Physical medicine treatment.

Decision rationale: MTUS and ODG guidelines recommend 10 physical therapy visits over 8 weeks for medical management of Rotator cuff impingement syndrome and 9 visits over 8 weeks for derangement of meniscus and Tibialis tendonitis. As time goes, one should see an increase in the active regimen of care or decrease in the passive regimen of care, with a fading of treatment frequency (from up to 3 or more visits per week to 1 or less). When the treatment duration and/or number of visits exceeds the guidelines, exceptional factors should be noted. The Injured worker complains of right shoulder and knee pain. Although Physical Therapy may be indicated, the current request exceeds the number of sessions recommended by guidelines. Documentation fails to show supporting exceptional factors. The request for Physical therapy, 12 sessions is not medically necessary per guidelines.

Right Knee Sleeve: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment in Workers' Compensation, Knee and Leg (Acute and Chronic), Knee Brace.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): Knee Complaints, Initial Care, pg 340. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee Chapter, Knee brace.

Decision rationale: Per guidelines, knee braces may be used in treating patients with conditions including Knee instability, ligament insufficiency/deficiency, reconstructed ligament, painful failed total knee arthroplasty and painful unicompartmental osteoarthritis. MTUS goes on to state that braces need to be used in conjunction with a rehabilitation program and that the benefits be more emotional (i.e., increasing the patient's confidence) than medical. The injured worker complains of right knee pain. Documentation fails to show objective findings of instability of the knee to warrant the use of a knee sleeve or brace. The request for a Right Knee Sleeve is not medically necessary by MTUS.

Hot and Cold Unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment in Workers' Compensation, Cold/heat packs.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): Initial Care, pg 203. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and shoulder Chapters, Heat/Cold Packs.

Decision rationale: ODG, MTUS and ODG recommend at-home local applications of cold in the first few days of acute complaint of pain, followed thereafter by applications of heat or cold. Per guidelines, patients at-home applications of heat or cold packs may be used before or after exercises and are as effective as those performed by a therapist. There is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful for pain reduction and return to normal function. The injured worker complains of right shoulder and knee pain. MTUS provides no evidence recommending the routine use of high tech devices over the use of local cold or heat wraps. The request for Hot and Cold Unit is not medically necessary per guidelines.