

Case Number:	CM15-0181171		
Date Assigned:	10/13/2015	Date of Injury:	02/18/2014
Decision Date:	11/18/2015	UR Denial Date:	09/01/2015
Priority:	Standard	Application Received:	09/14/2015

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 50 year old male, who sustained an industrial injury on February 18, 2014. The injured worker was currently diagnosed as having post traumatic cephalgia, chronic sprain and strain of cervical spine, chronic sprain and strain of thoracic spine, chronic sprain and strain of lumbar spine with radiculitis, chronic sprain and strain of bilateral shoulders with glenoid and rotator cuff partial tear, chronic sprain and strain of bilateral elbows with lateral epicondylitis, lateral epicondylitis bilateral, chronic sprain and strain of wrist and hand bilaterally, De Quervain's syndrome bilateral, ligament laxity medial and lateral collateral ligament right knee rule out tear, sprain and strain of left knee compensatory to the right, dust exposure, skin rashes secondary to dust exposure, stress and anxiety and insomnia secondary to anxiety and pain. Treatment to date has included diagnostic studies, physiotherapy, chiropractic treatment, medications and acupuncture. On August 17, 2015, the injured worker complained of neck pain with radiation to the bilateral shoulders associated with numbness and tingling, upper back pain radiating to the lower neck, low back pain radiating to the bilateral legs associated with numbness and tingling, right shoulder pain, left shoulder pain radiating to the arm associated with numbness and tingling, bilateral elbow pain radiating to the wrists associated with numbness and tingling, bilateral wrist pain associated with numbness and tingling and right knee pain. The injured worker also reported difficulty falling asleep, chest pain and depression. Physical examination revealed tenderness to palpation of the cervical spine, thoracic spine, lumbosacral spine, bilateral shoulders, bilateral elbows, bilateral wrists, bilateral hands and bilateral knees. Tennis elbow test was positive bilaterally. McMurray's test was

questionably positive on the right. Valgus-varus stress test was positive on the right. The treatment plan included Toradol injection, medications, acupuncture, physical therapy, home exercises and a possible interferential 4 unit. On September 1, 2015, utilization review denied a request for Zostrix gel #1, one functional capacity evaluation, one interferential current therapy 4 unit, one knee brace and Naprosyn 500mg #60. A request for eight therapeutic activity sessions, orthopedic surgeon consultation and eight sessions of acupuncture for neck, low and upper back and bilateral knees was conditionally non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Zostrix gel #1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

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 According to the California MTUS Guidelines (2009), topical analgesics are 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 topical analgesic compound is Capsaicin (Zostrix) gel. According to the MTUS, Capsaicin is recommended only as an option in patients who have not responded to or are intolerant of other treatments. There is a lack of documentation that the injured worker is intolerant of other treatments, therefore is not medically necessary.

1 Functional capacity evaluation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Fitness for Duty: Functional capacity evaluation (FCE).

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

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. It is not recommended routinely as part of occupational rehab or screening, or generic assessments in which the question is whether someone can do any type of job generally. According to the ODG, guidelines for performing an FCE: recommended prior to admission to a Work Hardening (WH) Program, with preference for assessments tailored to a specific task or job; if a worker is actively participating in determining the suitability of a particular job, the FCE is more likely to be successful. A FCE is not as effective when the referral is less collaborative and more directive; it is important to provide as much detail as possible about the potential job to the assessor. Job specific FCEs are more helpful than general assessments. FCE's should not be conducted unless maximum medical improvement (MMI) has been achieved or is anticipated to occur shortly. In this case, the injured worker was not close to MMI. The cited guideline criteria have not been met. 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.

1 Interferential current therapy (IF) 4 Unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Electrical stimulators (E-stim). 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. Interferential current works in a similar fashion as TENS, but at a substantially higher frequency (4000-4200 Hz). While not recommended as an isolated intervention, the following patient selection criteria should be documented by the medical care provider for Interferential Current Stimulation (ICS) to be determined to be medically necessary: Possibly appropriate for the following conditions if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical therapy: Pain is ineffectively controlled due to diminished effectiveness of medications; or Pain is ineffectively controlled with medications due to side effects; or History of substance abuse; or Significant pain from postoperative or acute conditions limits the ability to perform exercise programs/physical therapy treatment; or Unresponsive to conservative measures (e.g., repositioning, heat/ice,

medications, etc.). If those criteria are met, then a one-month trial may be appropriate to permit the physician and physical therapy provider to study the effects and benefits. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction. 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.

1 Knee brace: Upheld

Claims Administrator guideline: Decision based on MTUS Knee Complaints 2004.

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

Decision rationale: There is no documentation necessitating a right knee brace. According to ODG, a knee brace is indicated if there is evidence of knee instability. Bracing may be used for ACL tears or instability of the MCL or patella. It is only necessary when the knee is to be stressed under a significant load. However, for the average injury, it is not generally necessary. In this case, there is documentation of some MCL instability. However, even in the presence of MCL laxity, bracing is not supported unless the knee will be loaded significantly. Since this patient is unable to work in any capacity, medical necessity has not been established. The requested item is not medically necessary.

Naprosyn 500mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) NSAIDs.

Decision rationale: Naprosyn (Aleve or Naproxen) is a non-steroidal anti-inflammatory drug (NSAID). Oral NSAIDs are recommended for the treatment of chronic pain and control of inflammation as a second-line therapy after acetaminophen. The ODG states that NSAIDs are recommended for acute pain, osteoarthritis, acute low back pain (LBP) and acute exacerbations of chronic pain, and short-term pain relief in chronic LBP. There is no evidence of long-term effectiveness for pain or function. There is inconsistent evidence for the use of NSAIDs to treat long-term neuropathic pain. Guidelines recommended that the lowest effective dose be used for the shortest duration of time consistent with treatment goals. In this case, there was documentation of side effects related to previous NSAID use. In addition, there was no documentation of objective evidence of functional benefit from use of this medication. Medical necessity of the requested medication has not been established. The request for Naproxen is not medically necessary.