MAXIMUS Federal Services

Case Number:	CM15-0182631		
Date Assigned:	10/01/2015	Date of Injury:	05/07/2015
Decision Date:	12/09/2015	UR Denial Date:	09/02/2015
Priority:	Standard	Application Received:	09/16/2015

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: Tennessee, Florida, Ohio
Certification(s)/Specialty: Surgery, Surgical Critical Care

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 62 year old male, who sustained an industrial-work injury on 5-7-15. He reported initial complaints of pain to neck, wrists, and knees. The injured worker was diagnosed as having neck sprain-strain, brachial neuritis-radiculitis, thoracic sprain-strain, lumbar sprain-strain, thoraco-lumbosacral neuritis-radiculitis, sprain-strain of shoulder, forearm, wrist, and elbow, closed fracture of distal end of ulna, and sprain-strain of knee and leg and ankle. Treatment to date has included medication, physical therapy (6 sessions) with no benefit, activity modification, and diagnostics. Currently, the injured worker complains of bilateral wrist pain that radiates to his hands and fingers and rated pain at 6-7 out of 10. There is difficulty with grasping and repetitive hand movements. There is continued mid back pain which radiates to his lower extremities with pain rated at 7-9 out of 10. Pain medication helps relieve the pain. Per the primary treating physician's orthopedic consultation report (PR-2) on 8-14-15, exam revealed he had difficulty with lumbar range of motion. The knees have clicking, popping, and locking and give out. There is paraspinal tenderness in the thoracic spine, the knees have no erythema, effusions, or palpable masses. There is tenderness along the right medial meniscus, positive McMurray's testing, and wrist tenderness bilaterally. Neurological testing was negative. The Request for Authorization requested service to include PT 2x4 Lumbar Spine, Voltaren XR, Flurbiprofen/Ketoprofen Topical Cream, Gabapentin/Cyclobenzaprine/Capsaicin Topical Cream, Kronos Lumbar Pneumatic Brace, and Urine Drug Screen. The Utilization Review on 9-2-15 modified PT (6 sessions) Lumbar Spine and denied the request for Voltaren XR, Flurbiprofen/ Ketoprofen Topical Cream, Gabapentin/Cyclobenzaprine/Capsaicin Topical Cream, Kronos Lumbar Pneumatic Brace, and Urine Drug Screen, per CA MTUS (California Medical Treatment Utilization Schedule), Chronic Pain Medical Treatment Guidelines 2009.

IMR ISSUES, DECISIONS AND RATIONALES

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

PT 2x4 Lumbar Spine: Overturned

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): Physical Medicine.

Decision rationale: There is sufficient clinical information provided to justify the medical necessity of physical therapy for this patient. The value of physical therapy increases when a physician gives the therapist a specific diagnosis of the lesion causing the patient's symptoms. With a prescription that clearly states treatment goals, a physician can use communication with the therapist to monitor such variables as motivation and compliance. The California MTUS Guidelines state that physician should allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. Physical therapy is recommended by MTUS as follows: Myalgia and myositis, unspecified: 9-10 visits over 8 weeks; Neuralgia, neuritis, and radiculitis, unspecified: 8-10 visits over 4 weeks; Reflex sympathetic dystrophy: 24 visits over 16 weeks. This patient has been documented to have sprain to the lumbar spine. A total of 8 PT sessions, twice per week for 4 weeks has been requested as a trial of conservative therapy for this patient's industrial accident. Per MTUS guidelines, a trial of this size is warranted for treatment of the patient's pain. Therefore, based on the submitted medical documentation, the request for physical therapy is medically necessary.

Voltaren XR: 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, GI symptoms & cardiovascular risk.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of treatment of this medication for this patient. The California MTUS guidelines address the topic of NSAID prescriptions by stating, "A Cochrane review of the literature on drug relief for low back pain (LBP) suggested that NSAIDs were no more effective than other drugs such as acetaminophen, narcotic analgesics, and muscle relaxants. The review also found that NSAIDs had more adverse effects than placebo and acetaminophen but fewer effects than

muscle relaxants and narcotic analgesics." The MTUS guidelines do not recommend routine use of NSAIDS due to the potential for adverse side effects (GI bleeding, ulcers, renal failure, etc). The medical records do not support that the patient has a contraindication to other non-opioid analgesics. Therefore, medical necessity for Voltaren prescription has not been established. The request is not medically necessary.

Flurbiprofen/Ketoprofen Topical Cream: 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: There is not sufficient clinical information provided to justify the medical necessity of this medication for this patient. Per the California MTUS guidelines, topical NSAIDS are only recommended for "Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment." They should only be use for 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. Use for neuropathic pain is not recommended as there is no evidence to support use. This patient has been documented to chronic pain secondary to his industrial accident. He has no evidence of osteoarthritis or tendinitis, particularly of the knee or elbow. Per MTUS, topical NSAID application is not warranted for this indication. Therefore, based on the submitted medical documentation, the request for flurbiprofen/ketoprofen cream is not medically necessary.

Gabapentin/Cyclobenzaprine/Capsaicin Topical Cream: 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: There is not sufficient clinical information provided to justify the medical necessity of this medication for this patient. Per the California MTUS Chronic Pain guidelines, topical analgesics are not recommended as an option for chronic pain control and are largely experimental in use with few randomized control trials to determine efficacy or safety. Any compounded product that contains at least one drug or drug class that is not recommended is not recommended as a whole. The requested cream is a combination of multiple medications. Compounded medications are not FDA approved or recommended by ODG guidelines due to concerns of purity and efficacy. Hence the request for this compounded medication is not appropriate or indicated by MTUS and ODG guidelines. Therefore, based on the submitted medical documentation, the request for Gabapentin/Cyclobenzaprine/Capsaicin is not medically necessary.

Kronos Lumbar Pneumatic Brace: 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 ODG, Low Back - Lumbar & Thoracic (Acute & Chronic), Lumbar supports.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this request for this patient. MTUS and ACOEM fail to address this topic. Per ODG, lumbar support braces are: "Recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific LBP (very low-quality evidence, but may be a conservative option)." This patient does not have clear evidence of fracture, instability of the spine or nonspecific pain. Pain is documented as a "sprain" with minimal conservative therapy tried and failed since this patient's industrial accident. Therefore, based on the submitted medical documentation, the request for lumbar brace is not medically necessary.

Urine Drug Screen: 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): Drug testing.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of a urine drug screen for this patient. The clinical records submitted do not support the fact that this patient has been documented to have a positive drug screen for illicit or non-prescribed substances. The MTUS guidelines recommend frequent and random urine drug screens where aberrant behavior is suspected. This patient has not been documented to have suspicion of aberrant behavior. His pain is documented as well controlled and past drug use is consistent with currently prescribed medications. Therefore, based on the submitted medical documentation, the request for drug screening is not medically necessary.