

Case Number:	CM15-0206782		
Date Assigned:	10/26/2015	Date of Injury:	08/31/2015
Decision Date:	12/30/2015	UR Denial Date:	09/27/2015
Priority:	Standard	Application Received:	10/21/2015

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

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 79 year old male, who sustained an industrial injury on 8-31-2015. The injured worker is undergoing treatment for lumbosacral strain-sprain, lumbosacral radiculopathy, rule out lumbosacral discogenic disease, left hip strain-sprain, left knee strain-sprain, left ankle strain-sprain, rule out left ankle internal derangement and left foot tenosynovitis. Medical records dated 9-9-2015 indicate the injured worker complains of back and left leg, knee, ankle, and foot pain. Physical exam dated 9-9-2015 notes antalgic gait, lumbar, sacroiliac, left knee, left hip, and left ankle tenderness to palpation, spasm and decreased range of motion (ROM) with left lower extremity decreased strength, positive straight leg raise on the left and positive FABRE test. The injured worker is working with restrictions. A report dated October 21, 2015 indicates that the patient has completed 3 sessions of physical therapy. Urine toxicology is recommended for medication monitoring. The original utilization review dated 9-27-2015 indicates the request for urine toxicology is certified and Transcutaneous Electrical Nerve Stimulation (TENS) unit, web education classes, lumbosacral brace, electromyogram-nerve conduction study, X-rays, extracorporeal shockwave therapy (ECSWT), Tramadol 50mg #60, Theramine #90 and Flurbi (NAP) Cream - LA (Flurbiprofen 20%, Lidocaine 5%, Amitriptyline 5%) 180gm is non-certified and physical therapy 3X4 and Fexmid 7.5mg #90 is modified.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS Unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Electrical stimulators (E-stim).

Decision rationale: Regarding the request for TENS, Chronic Pain Medical Treatment Guidelines state that transcutaneous electrical nerve stimulation (TENS) is not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option if used as an adjunct to a program of evidence-based functional restoration. Guidelines recommend failure of other appropriate pain modalities including medications prior to a TENS unit trial. Prior to TENS unit purchase, one month trial should be documented as an adjunct to ongoing treatment modalities within a functional restoration approach, with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function. Within the documentation available for review, there is no indication that the patient has undergone a TENS unit trial, and no documentation of any specific objective functional deficits which a tens unit trial would be intended to address. Additionally, it is unclear what other treatment modalities are currently being used within a functional restoration approach. In the absence of clarity regarding those issues, the currently requested TENS unit 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: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Education, Exercise.

Decision rationale: Regarding the request for "patient education Web classes," it is unclear what is being requested. Chronic Pain Medical Treatment Guidelines recommend education in biomechanics and exercise to improve patient outcomes and decrease the risk of re-injury. Guidelines state that the physician can provide such instruction. It is unclear why additional resources would be needed to instruct the patient at the current time. Additionally, it is unclear exactly what is intended to be addressed with the currently requested "Web classes." In the absence of clarity regarding those issues, the currently requested "patient education Web classes," are not medically necessary.

Physical Therapy 3 Times a Week for 4 Weeks for Lumbar Spine, Left Hip, Left Knee, Left Ankle, and Left Foot: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Physical Therapy.

Decision rationale: Regarding the request for additional physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, there is documentation of completion of prior PT sessions, but there is no documentation of specific objective functional improvement with the previous sessions and remaining deficits that cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. Furthermore, the request exceeds the amount of PT recommended by the CA MTUS and, unfortunately, there is no provision for modification of the current request. In light of the above issues, the currently requested additional physical therapy is not medically necessary.

Lumbosacral Brace: Upheld

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

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Initial Care. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Lumbar Supports.

Decision rationale: Regarding the request for Lumbosacral Brace, ACOEM guidelines state that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. ODG states that lumbar supports are not recommended for prevention. They go on to state the lumbar support are recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific low back pain. ODG goes on to state that for nonspecific low back pain, compared to no lumbar support, elastic lumbar belt maybe more effective than no belt at improving pain at 30 and 90 days in people with subacute low back pain lasting 1 to 3 months. However, the evidence was very weak. Within the documentation available for review, it does not appear that this patient is in the acute or subacute phase of his treatment. Additionally, there is no documentation indicating that the patient has a diagnosis of compression fracture, spondylolisthesis, or instability. As such, the currently requested Lumbosacral Brace is not medically necessary.

EMG/NCV Bilateral Lower Extremities: Upheld

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

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Electrodiagnostic Studies.

Decision rationale: Regarding the request for EMG/NCV of the lower extremities, Occupational Medicine Practice Guidelines state that unequivocal objective findings that identify specific nerve compromise on the neurologic exam are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery. When a neurologic examination is less clear however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. They go on to state that electromyography may be useful to identify subtle focal neurologic dysfunction in patients with low back symptoms lasting more than 3 to 4 weeks. ODG states that nerve conduction studies are not recommended for back conditions. They go on to state that there is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. Within the documentation available for review, there are no physical examination findings supporting a diagnosis of specific nerve compromise. Additionally, if such findings are present but have not been documented, there is no documentation that the patient has failed conservative treatment directed towards these complaints. In the absence of such documentation, the currently requested EMG/NCV of the lower extremities is not medically necessary.

X-Ray of the Lumbosacral Spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Radiography (X-rays).

Decision rationale: Regarding request for lumbar spine x-ray, Occupational Medicine Practice Guidelines state that x-rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology even if the pain has persisted for at least 6 weeks. However, it may be appropriate when the physician believes it would aid in patient management. Guidelines go on to state that subsequent imaging should be based on new symptoms or a change in current symptoms. Within the documentation available for review, it does not appear that the patient has failed conservative treatment prior to the request for imaging. Additionally, the requesting physician has not stated how his medical decision-making will be changed based upon the outcome of the currently requested lumbar x-ray. In the absence of clarity regarding those issues, the currently requested lumbar x-ray is not medically necessary.

X-Ray of the Left Ankle: Upheld

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

MAXIMUS guideline: Decision based on MTUS Ankle and Foot Complaints 2004, Section(s): Special Studies.

Decision rationale: Regarding the request for x-ray of the ankle, ACOEM guidelines state that special studies are not needed to evaluate most complaints until after a period of conservative care and observation. Within the documentation available for review, it does not appear that the patient has failed conservative treatment prior to the request for imaging. Additionally, the requesting physician has not stated how his medical decision-making will be changed based upon the outcome of the currently requested ankle x-ray. In the absence of clarity regarding those issues, the currently requested repeat x-ray of the ankle is not medically necessary.

X-Ray of the Left Foot: Upheld

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

MAXIMUS guideline: Decision based on MTUS Ankle and Foot Complaints 2004, Section(s): Special Studies.

Decision rationale: Regarding the request for x-ray of the Left Foot, ACOEM guidelines state that special studies are not needed to evaluate most complaints until after a period of conservative care and observation. Within the documentation available for review, it does not appear that the patient has failed conservative treatment prior to the request for imaging. Additionally, the requesting physician has not stated how his medical decision-making will be changed based upon the outcome of the currently requested Left Foot x-ray. In the absence of clarity regarding those issues, the currently requested x-ray of the Left Foot is not medically necessary.

ECSWT, Left Foot, 1 Time a Week for 4 Weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS Ankle and Foot Complaints 2004, Section(s): Physical Methods. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Ankle and Foot Chapter, Plantar Fasciitis.

Decision rationale: Regarding the request for ECSWT, Left Foot, Occupational Medicine Practice Guidelines recommend the use of ESWT as an optional treatment for plantar fasciitis. ODG states that low energy ESWT is recommended as an option for chronic plantar fasciitis. The criteria include heel pain from plantar fasciitis that has lasted for at least 6 months with failure of at least 3 conservative treatment measures. They recommend a maximum of 3 therapy sessions over 3 weeks. Within the documentation available for review, there is no indication that the patient has plantar fasciitis or has failed conservative treatment for this diagnosis. Additionally, ESWT is not indicated in the treatment of lumbar spine disorders. As such, the currently requested ECSWT, Left Foot is not medically necessary.

Tramadol 50mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids (Classification), Opioids, California Controlled Substance Utilization Review and Evaluation System (CURES) [DWC], Opioids, criteria for use, Opioids for chronic pain, Opioids for neuropathic pain, Opioids for osteoarthritis, Opioids, cancer pain vs. nonmalignant pain, Opioids, dealing with misuse & addiction, Opioids, differentiation: dependence & addiction, Opioids, dosing, Opioids, indicators for addiction, Opioids, long-term assessment.

Decision rationale: Regarding the request for Ultram (tramadol), California Pain Medical Treatment Guidelines state that this is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no indication that the medication is improving the patient's function or pain (in terms of specific examples of functional improvement and percent reduction in pain or reduced NRS), no documentation regarding side effects, and no discussion regarding aberrant use. As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested Ultram (tramadol) is not medically necessary.

Theramine #90 (1 Bottle): 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) Pain Chapter, Theramine.

Decision rationale: Regarding the request for Theramine, California MTUS and ACOEM Guidelines do not contain criteria for the use of medical foods. ODG states Theramine is not recommended. It is intended for use in the management of pain syndromes that include acute pain, chronic pain, fibromyalgia, neuropathic pain, and inflammatory pain. Until there are higher quality studies of the ingredients in Theramine, it remains not recommended. As such, the currently requested Theramine is not medically necessary.

Fexmid (Cyclobenzaprine) 7.5mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

Decision rationale: Regarding the request for cyclobenzaprine (Fexmid), Chronic Pain Medical Treatment Guidelines support the use of non-sedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Guidelines go on to state that cyclobenzaprine specifically is recommended for a short course of therapy. Within the documentation available for review, there is no identification of a specific analgesic benefit or objective functional improvement as a result of the cyclobenzaprine. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. In the absence of such documentation, the currently requested cyclobenzaprine (Fexmid) is not medically necessary.

Flurbi (NAP) Cream - LA (Flurbiprofen 20%, Lidocaine 5%, Amitriptyline 5%) 180gm:
Upheld

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

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

Decision rationale: Regarding the request for Flurbi (NAP) Cream - LA (Flurbiprofen 20%, Lidocaine 5%, Amitriptyline 5%) 180gm, CA MTUS states that topical compound medications require guideline support for all components of the compound in order for the compound to be approved. Topical lidocaine is "Recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica)." Additionally, it is supported only as a dermal patch. Guidelines do not support the use of topical antidepressants. As such, the currently requested Flurbi (NAP) Cream - LA (Flurbiprofen 20%, Lidocaine 5%, Amitriptyline 5%) 180gm is not medically necessary.