

Case Number:	CM15-0034176		
Date Assigned:	04/01/2015	Date of Injury:	12/19/2014
Decision Date:	05/15/2015	UR Denial Date:	02/12/2015
Priority:	Standard	Application Received:	02/23/2015

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

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 38-year-old male who reported an injury on 12/19/2014. The documentation of 01/12/2015 revealed the mechanism of injury was cumulative trauma. The injured worker had skin irritation and dermatitis secondary to chemical exposure due to acid leaking from batteries. The injured worker complained of 3 headaches per week; continuous pain in the bilateral shoulders, right elbow, and forearm; and intermittent pain in the left elbow and forearm. The injured worker had complaints of frequent bilateral wrist and hand pain with associated numbness, tingling, weakness, and loss of grip in the bilateral hands, continuous low back pain and frequent bilateral knee pain, and frequent bilateral foot pain and complained of anxiety, depression, and insomnia. The surgical history was stated to be none. The current medications included Motrin. The physical examination revealed tenderness over the bilateral paraspinals, suboccipital, upper trapezius, and sternocleidomastoid muscles with a positive cervical compression test, decreased range of motion of the cervical spine and tenderness over the bilateral thoracic paraspinals and tenderness over the spinous processes from T1 through T6, tenderness in the bilateral lumbar paraspinals, quadratus lumborum, and gluteal. The injured worker had positive straight leg raises bilaterally and decreased range of motion of the lumbar spine. The injured worker had tenderness to palpation of the bilateral upper trapezius, rhomboids, and rotator cuffs with spasms with positive impingement signs bilaterally. The injured worker had decreased range of motion of the bilateral shoulders with tenderness and spasm over the flexor muscles and extensor muscles bilaterally. There was tenderness in the olecranon bilaterally with decreased range of motion of the bilateral elbows. There was

decreased range of motion of the bilateral wrists and hands and positive Tinel's bilaterally with crepitus. There was tenderness over the left thenar. There was tenderness over the medial knee, lateral knee, and popliteal knee bilaterally with positive McMurray's and decreased range of motion. The injured worker had tenderness over the medial ankle, lateral ankle, and calcaneus bilaterally with decreased range of motion. The diagnoses included cervical spine, thoracic spine, lumbar spine, bilateral shoulder, bilateral elbow, bilateral wrist, and bilateral knee sprain and strain, bilateral ankle sprain and strain, and rule out contact dermatitis of the bilateral forearms. The treatment plan included cyclobenzaprine 5 mg #60, naproxen 550 mg #60, omeprazole 20 mg #30, and triamcinolone acetonide 30 mg; topical compounds; physical therapy 3 times a week for 4 weeks; x-rays of the cervico-, thoraco- and lumbar spine, bilateral wrists, and bilateral knees; and a consultation for internal medicine. Additional requests included a functional capacity evaluation and a urine toxicology screen as well as a lumbar spine support.

IMR ISSUES, DECISIONS AND RATIONALES

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

Omeprazole 20mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms and cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 69.

Decision rationale: The California MTUS Guidelines recommend proton pump inhibitors for injured workers at intermediate risk or higher for gastrointestinal events and are also for the treatment of dyspepsia secondary to NSAID therapy. The clinical documentation submitted for review failed to provide a rationale for the requested omeprazole. There was a lack of documentation indicating the injured worker was at intermediate or high risk for gastrointestinal events. There was a lack of documentation of gastrointestinal complaints. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for omeprazole 20 mg #30 is not medically necessary.

Triamcinolone acetonide 30mg: 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 Other Medical Treatment Guideline or Medical Evidence: <http://www.drugs.com/mtm/triamcinolone-topical.html>.

Decision rationale: Per Drugs.com, "Triamcinolone topical is used to treat the inflammation caused by a number of conditions such as allergic reactions, eczema, and psoriasis. The dental paste form of triamcinolone is used to treat mouth ulcers." There was a lack of documentation

indicating a necessity for both a topical and oral steroid. There was a lack of documented rationale for the use of triamcinolone acetonide. The request as submitted failed to indicate the body part and the frequency for the requested medication. Given the above, the request for triamcinolone acetonide 30 mg is not medically necessary.

Flurbiprofen 20%, Baclofen 10%, Dexamethasone 2% 240gms in cream base: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Salicylate Topicals, Flurbiprofen, Baclofen Page(s): 111, 105, 72, 113. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: <http://www.drugs.com/search.php?searchterm=dexamethasone&a=1>.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines indicate that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Regarding Topical flurbiprofen, FDA approved routes of administration for flurbiprofen include oral tablets and ophthalmologic solution. A search of the National Library of Medicine - National Institute of Health (NLM-NIH) database demonstrated no high quality human studies evaluating the safety and efficacy of this medication through dermal patches or topical administration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2 week period. Salicylate topicals are recommended. There is no peer reviewed literature to support the use of topical baclofen. Per Drugs.com, "Dexamethasone is a corticosteroid that prevents the release of substances in the body that cause inflammation. Dexamethasone is used to treat many different inflammatory conditions such as allergic disorders, skin conditions, ulcerative colitis, arthritis, lupus, psoriasis, or breathing disorders." There was a lack of documentation indicating a necessity for both a topical and oral steroid. There was a lack of documentation indicating the injured worker had a trial and failure of antidepressants and anticonvulsants. As multiple components in the topical are not recommended, this medication would not be supported. The request as submitted failed to indicate the frequency and body part to be treated. Given the above, the request for flurbiprofen 20%, baclofen 10%, dexamethasone 2% 240 gms in cream base is not medically necessary.

Gabapentin 10%, Amitriptyline 10%, Bupivacaine 5% 240gm cream base: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Antidepressants, Topical Antiepileptic Medications Page(s): 111, 13, 113. Decision

based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence:
Skolnick P (1999) Antidepressants for the new millennium. Eur J Pharmacol 375:31-40.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines indicate that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety and are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Peer reviewed literature states that while local peripheral administration of antidepressants has been demonstrated to produce analgesia in the formalin model of tonic pain; a number of actions, to include inhibition of noradrenaline (NA) and 5-HT reuptake, inhibition of NMDA, nicotinic, histamine, and 5-HT receptors, and block of ion channels and even combinations of these actions, may contribute to the local peripheral efficacy of antidepressant; therefore the contribution of these actions to analgesia by antidepressants, following either systemic or local administration, remains to be determined. Bupivacaine has been recommended as an alternative to clonidine; however a search of FDA guidelines indicate that Bupivacaine is approved for injection. There was a lack of documentation indicating the injured worker had a trial of antidepressants and anti-convulsants. There was a lack of documentation of exceptional factors to warrant non-adherence to guideline recommendations. There was a lack of documentation indicating that bupivacaine had been approved for topical applications. The request as submitted failed to indicate the frequency and body part to be treated. Given the above, the request for gabapentin 10%, amitriptyline 10%, bupivacaine 5% 240 gms cream base is not medically necessary.

X-ray cervico- thoraco -lumbar spine, bilateral wrist & bilateral knees: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 182, 177, 178, 267 268 and 343.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 12 Low Back Complaints, Chapter 13 Knee Complaints Page(s): 177-179, 268-269, 303-305, 341-343.

Decision rationale: The ACOEM Guidelines indicate that special studies are not necessary for neck or upper back problems unless a 3 or 4-week period of conservative care and observation fails to improve symptoms. Lumbar spine x-rays are not recommend for injured workers 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. It may be appropriate when the physician opines it would aid in injured worker management. The referenced guidelines indicate that regarding x-rays for the hands or wrists, for injured workers presenting with true hand or wrist problems, special studies are not needed until after a 4 to 6 week period of conservative care and observation and the same was noted for the knees. There was a lack of documentation indicating the injured worker had undergone 6 to 8 weeks of conservative care. The specific conservative care for each body part was not provided. Given the above, the request for x-ray cervico- thoraco lumbar spine, bilateral wrist and bilateral knees is not medically necessary.

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 (ODG) Fitness for Duty (acute & chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness for Duty Chapter, FCE.

Decision rationale: The American College of Occupational and Environmental Medicine Guidelines indicate there is a functional assessment tool available and that is a Functional Capacity Evaluation. However, it does not address the criteria. As such, secondary guidelines were sought. The Official Disability Guidelines indicates that a Functional Capacity Evaluation is appropriate when a worker has had prior unsuccessful attempts to return to work. There was a lack of documentation indicating the injured worker had a prior unsuccessful return to work. Given the above, the request for a Functional Capacity Evaluation is not medically necessary.

Urine Toxicology with Chromatography: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria or use of urine drug testing. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (acute & chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ongoing Management Page(s): 78.

Decision rationale: The California MTUS indicates that the use of urine drug screening is for injured workers with documented issues of abuse, addiction, or poor pain control. The clinical documentation submitted for review failed to provide documentation the injured worker had issues of abuse, addiction, or poor pain control. Given the above, the request for urine toxicology with chromatography is not medically necessary.

Lumbar Spine Support: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298 and 301.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

Decision rationale: The American College of Occupational and Environmental Medicine Guidelines indicate that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. Additionally, continued use of back braces could lead to deconditioning of the spinal muscles. There was a lack of documentation indicating the injured worker had spinal instability. The rationale for the use of the lumbar spine brace was not provided. Given the above, the request for a lumbar spine support is not medically necessary.

12 Physical Therapy visits to include infrared, massage, myofascial release and electro-stimulation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Physical Therapy Guidelines; Neck & Upper Back (acute & chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98, 99.

Decision rationale: The California MTUS Guidelines indicate that physical medicine treatment is appropriate for up to 10 visits for myalgia, myositis, and radiculitis. The clinical documentation submitted for review failed to provide documentation of objective functional deficits. There was a lack of documentation indicating prior therapies. The request for 12 sessions would be excessive. The request as submitted failed to indicate the body part or parts to be treated with physical medicine. As the therapy is noted to be excessive, and there is a lack of documentation of prior therapies with remaining objective functional deficits, the requests for infrared, massage, myofascial release, and electro stimulation would not be appropriate. Given the above, the request for 12 physical therapy visits to include infrared, massage, myofascial release, and electro-stimulation is not medically necessary.