

Case Number:	CM15-0035672		
Date Assigned:	03/27/2015	Date of Injury:	07/16/2014
Decision Date:	05/15/2015	UR Denial Date:	02/12/2015
Priority:	Standard	Application Received:	02/25/2015

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 20-year-old female who reported an injury on 11/21/2014. The mechanism of injury was cumulative trauma. Prior therapies included physical therapy, chiropractic care, acupuncture, and topical medications. There was a Request for Authorization submitted for review dated 02/04/2015. The documentation of 02/04/2015 revealed the injured worker had neck pain associated with headaches radiating to the right more than left shoulder and therapy was helping. The injured worker had dull aching pain radiating to the bilateral lower extremities; therapy helped. The injured worker had bilateral shoulder pain and bilateral knee pain. The injured worker had tenderness to palpation of the bilateral trapezii and cervical paravertebral muscles and tenderness to palpation of the bilateral gluteus, L3-5 spinous processes, lumbar paravertebral muscles, and spinous processes. The range of motion of the cervical spine, lumbar spine, right shoulder, and left shoulder were within normal limits. There was a negative Neer's and Hawkins test bilaterally. The diagnosis included cervical muscle spasms, cervical musculoligamentous injury, lumbago, lumbar myospasm, lumbosacral sprain and strain, right shoulder muscle spasms, right shoulder pain, bilateral shoulder sprain and strain, and bilateral knee sprain and strain. The treatment plan included an x-ray of the cervical spine, lumbar spine, left knee, and right knee; continue current medications including naproxen 550 mg 1 by mouth as needed #60 for inflammation and pain, pantoprazole by mouth as needed #60 to protect GI system, and topical compounds were dispensed including gabapentin 10%/amitriptyline 10%/bupivacaine 5%, and flurbiprofen 20%/baclofen 10%/dexamethasone

2%; continue therapy, acupuncture, and chiropractic treatment; x-rays of the cervical spine, lumbar spine, and bilateral knees; TENS unit; hot and cold therapy; and return to clinic.

IMR ISSUES, DECISIONS AND RATIONALES

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

Functional Capacity Exam: 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).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92. 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. The clinical documentation failed to indicate the injured worker had a failed attempt to return to work. There was a lack of documentation of exceptional factors. Given the above, the request for Functional Capacity Exam is not medically necessary.

Physical Therapy x 8 visits: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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

Decision rationale: The California MTUS Guidelines indicate that up to 10 sessions of physical medicine are appropriate for the treatment of myalgia and myositis, as well as radiculitis. The clinical documentation submitted for review indicated the injured worker had undergone physical medicine treatment. There was a lack of documentation of objective functional benefit and objective functional deficits remaining to support the necessity for continued treatment. Additionally, the request as submitted failed to indicate the body parts to be treated. Given the above, the request for physical therapy x8 visits is not medically necessary.

Acupuncture x 8 visits: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The California Medical Treatment Utilization Schedule guidelines state that acupuncture is used as an option when pain medication is reduced or not tolerated and it is recommended as an adjunct to physical rehabilitation. Acupuncture treatments may be extended if functional improvement is documented including either a clinically significant improvement in activities of daily living or a reduction in work restrictions. The clinical documentation submitted for review indicated the injured worker had previously undergone acupuncture treatment. There was a lack of documentation of a clinically significant improvement in activities of daily living or a reduction in work restrictions. The request submitted failed to indicate the body part to be treated. There was a lack of documentation indicating the injured worker was utilizing the treatment as an option when pain medications were reduced or not tolerated. Given the above, the request for acupuncture x8 visits is not medically necessary.

Extracorporeal Shock Wave Therapy: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Peer reviewed literature: Extracorporeal Shock Wave Therapy for Orthopedic conditions.

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: Wang, Ching-Jen. "Extracorporeal shockwave therapy in musculoskeletal disorders." Journal of orthopaedic surgery and research 7.1 (2012): 1-8.

Decision rationale: Per Wang, Ching-Jen (2012), "The application of extracorporeal shockwave therapy (ESWT) in musculoskeletal disorders has been around for more than a decade and is primarily used in the treatment of sports related over-use tendinopathies such as proximal plantar fasciitis of the heel, lateral epicondylitis of the elbow, calcific or non-calcific tendonitis of the shoulder and patellar tendinopathy etc." The clinical documentation submitted for review failed to provide rationale for the request. The request as submitted failed to indicate the quantity, frequency, and body part to be treated. Given the above, the request for extracorporeal shockwave therapy is not medically necessary.

Trigger Points Impedance Imaging: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Guidelines Clearinghouse.

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.ncbi.nlm.nih.gov/pmc/articles/PMC3700778/> accessed 5-10-15.

Decision rationale: Per the National Institutes of Health, "A novel, noninvasive, image-guided, targeted neurostimulation modality that combines impedance imaging to locate the ATPs and treatment based on the image analysis was found very effective clinically in 95% of patients after a series of four treatments. This promising result warrants future investigation and randomize,

controlled, longitudinal studies in the treatment of LBP." The clinical documentation submitted for review failed to provide a rationale for the requested trigger point impedance imaging. The quantity of trigger point impedance imaging was not provided. The specific body part to be imaged were not noted per the request. Given the above, the request for trigger points impedance imaging is not medically necessary.

Localized Intense Neurostimulation Therapy: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Library of Medicine, The Chronic Pain Disorder Medical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NMES, TENS Page(s): 121, 114-116.

Decision rationale: The California Medical Treatment & Utilization Schedule guidelines indicate that a neuromuscular electrical stimulation (NMES devices) is not recommended. NMES is used primarily as part of a rehabilitation program following stroke and there is no evidence to support its use in chronic pain. There are no intervention trials suggesting benefit from NMES for chronic pain. A one month trial of a TENS unit is recommended if it is used as an adjunct to a program of evidence-based functional restoration for chronic neuropathic pain. Prior to the trial there must be documentation of at least three months of pain and evidence that other appropriate pain modalities have been tried (including medication) and have failed. The clinical documentation submitted for review failed to provide documentation of exceptional factors to support nonadherence to guideline recommendations. The request as submitted failed to indicate the body part and the frequency for the request. Given the above, the request for localized intense neurostimulation therapy is not medically necessary.

Pantoprazole #60: 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).

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 indicated the injured worker was utilizing the medication prophylactically for the stomach protection. However, there was a lack of documentation indicating the injured worker had signs or symptoms of dyspepsia and there was a lack of documentation indicating the injured worker was at intermediate risk or higher for gastrointestinal events. The request as submitted failed to indicate the frequency the strength for the requested medication. Given the above, the request for pantoprazole #60 is not medically necessary.

Retro (DOS 2/4/15): Gabapentin 10%, Amitriptyline 10%, Bupivacaine 5%: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Antidepressants, Topical Antiepileptic Medications, Bupivacaine Page(s): 111, 13, 113, 55. 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 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. The clinical documentation submitted for review failed to provide documentation that a trial of antidepressants and anticonvulsants have failed. There was a lack of documentation of exceptional factors to support the necessity for the use of bupivacaine as the research indicated bupivacaine was supported for injection, not for topical use. There was a lack of documented rationale for two topicals with muscle relaxants. The request as submitted failed to indicate the body part, frequency, and the quantity of medication being requested. Given the above, the request for Retro (DOS 2/4/15): Gabapentin 10%, Amitriptyline 10%, Bupivacaine 5%: is not medically necessary.

Retro (DOS 2/4/15): Flurbiprofen 20%, Baclofen 10%, Dexamethasone 2%: Upheld

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

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 indicates that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. 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." Capsaicin: Recommended only as an option in patients who have not responded or are intolerant to other treatments. The clinical documentation submitted for review failed to provide documentation that the injured worker had a trial and failure of oral antidepressants and anticonvulsants. There was a lack of documentation of exceptional factors to warrant nonadherence to guideline recommendations. The rationale for the use of dexamethasone in the topical was not provided. There was a lack of documented rationale for two topicals with muscle relaxants. The request as submitted failed to indicate the frequency and the body part to be treated, as well as the quantity of medication being requested. Given the above, the request for Retro (DOS 2/4/15): Flurbiprofen 20%, Baclofen 10%, Dexamethasone 2% is not medically necessary.

X-ray Bilateral Knees: 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).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 341-343.

Decision rationale: The ACOEM Guidelines indicate that special studies are not needed to evaluate most knee complaints until after a period of conservative care. The clinical documentation submitted for review failed to provide documentation the injured worker had objective findings upon physical examination to support the necessity for x-rays. There was a lack of documentation of the conservative care that was specifically directed at the knees. Given the above, the request for x-rays bilateral knees is not medically necessary.

TENS Unit x 5 months: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS unit Page(s): 114-116.

Decision rationale: The California Medical Treatment & Utilization Schedule Guidelines indicate that a one month trial of a TENS unit is recommended if it is used as an adjunct to a program of evidence-based functional restoration for chronic neuropathic pain. Prior to the trial there must be documentation of at least three months of pain and evidence that other appropriate pain modalities have been tried (including medication) and have failed. The clinical documentation submitted for review failed to provide documentation of a 1 month trial. There was a lack of documentation of exceptional factors to warrant nonadherence to guideline recommendations. There was a lack of documentation indicating other pain modalities had been trialed and failed. The request for 5 months would be excessive. The request as submitted failed to indicate the body part to be treated and whether the unit was for rental or purchase. There was a lack of documentation indicating the body part to be treated. Given the above, the request for TENS unit x5 months is not medically necessary.

Hot /Cold Unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Guidelines Clearinghouse.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 337.

Decision rationale: The ACOEM Guidelines indicate that at home local applications of hot and cold packs during the first few days of an acute complaint are appropriate and thereafter, there should be applications of heat packs. The clinical documentation submitted for review failed to provide documentation for a necessity for a hot and cold unit. There was a lack of documentation indicating the injured worker could not utilize at home hot and cold packs. The request as submitted failed to indicate the duration, frequency, and whether the unit was for rental or purchase. Given the above, the request for hot/cold unit is not medically necessary.

Chiropractic x 8 visits: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy Page(s): 58, 59.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines state that manual therapy and manipulation is recommended for chronic pain if caused by musculoskeletal conditions. For the low back, therapy is recommended initially in a therapeutic trial of 6 sessions and with objective functional improvement a total of up to 18 visits over 6-8 weeks may be appropriate. Treatment for flare-ups requires a need for re-evaluation of prior treatment success. Treatment is not recommended for the ankle & foot, carpal tunnel syndrome, the forearm, wrist, & hand or the knee. If chiropractic treatment is going to be effective, there should be some outward sign of subjective or objective improvement within the first 6 visits. Care beyond 8 weeks may be indicated for certain chronic pain patients in whom manipulation is

helpful in improving function, decreasing pain and improving quality of life. The clinical documentation submitted for review indicated the injured worker had prior chiropractic care. There was a lack of documentation indicating the injured worker had an improvement in function and decreased pain, as well as improvement in quality of life. The quantity of sessions were not provided. The request as submitted failed to indicate the body part to be treated. Given the above, the request for chiropractic x8 visits is not medically necessary.