MAXIMUS Federal Services

Case Number:	CM15-0059970		
Date Assigned:	04/06/2015	Date of Injury:	01/15/2015
Decision Date:	05/27/2015	UR Denial Date:	03/24/2015
Priority:	Standard	Application Received:	03/30/2015

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 35 year old male who sustained an industrial injury to his left knee on January 15, 2015 due to cumulative trauma. The injured worker was diagnosed with rule out left knee meniscus tear. Treatment to date has included conservative measures, acupuncture therapy and diagnostic testing. According to the primary treating physician's progress report on February 3, 2015, the injured worker continues to experience left knee pain. Examination of the left knee demonstrated painful, decreased range of motion with stiffness, numbness and tenderness to palpation of the posterior aspect with muscle spasm. There was no swelling noted. McMurray's test was positive. The injured worker is not on medications as noted in the documentation. Treatment plan consists of acupuncture therapy, chiropractic therapy, physical therapy, psychological evaluation, durable medical equipment, urine drug screening and the specific requested treatment for Cold/heat therapy unit, Functional Capacity Evaluation (FCE) testing, DNA testing, VSNCT (Voltage-Actuated Sensory Nerve Conduction Threshold) and topical analgesics.

IMR ISSUES, DECISIONS AND RATIONALES

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

Gabapentin 15%, Amitriptyline 4%, Dextromethrophan 10% 180 grams: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints,Chronic Pain Treatment Guidelines Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-knee chapter.

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. http://www.drugs.com/dextromethorphan.html.

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. Per Drugs.com, Dextromethorphan is a cough suppressant. It affects the signals in the brain that trigger cough reflex. There was a lack of documentation of a trial and failure of antidepressants and anticonvulsants. There was a lack of documentation of exceptional factors. The rationale for the use of dextromethorphan and amitriptyline topically was not provided. Additionally, the request as submitted failed to indicate the frequency and the body part to be treated. There was a lack of documentation indicating a necessity for 2 compounds with gabapentin as 1 of the ingredients. Given the above, the request for Gabapentin 15%, Amitriptyline 4%, Dextromethorphan 10% 180 grams is not medically necessary.

Capsaicin 0.025%, Flurbiprofen 15%, Gabapentin 10%, Menthol 2%, Camphor 2% 180 grams: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints, Chronic Pain Treatment Guidelines Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-knee chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Flurbiprofen, Topical analgesics, Topical Capsaicin, Salicylates topicals, Gabapentin Page(s): 72, 111, 28, 105, 113.

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. 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. Flurbiprofen is classified as a non-steroidal anti-inflammatory agent. This agent is not currently FDA approved for a topical application. 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 Capsaicin: Recommended only as an option in patients who have not responded or are intolerant to other treatments. Gabapentin: Not recommended. There is no peer-reviewed literature to support use Salicylate topicals are recommended. The clinical documentation submitted for review failed to provide documentation that the injured worker had utilized and failed an antidepressant and anticonvulsant. There was a lack of documentation indicating the injured worker had arthritis to support the use of topical NSAIDs. There was a lack of documentation indicating a necessity for 2 compounded medications with gabapentin. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for Capsaicin 0.025%, Flurbiprofen 15%, Gabapentin 10%, Menthol 2%, Camphor 2% 180 grams is not medically necessary.

Cold/heat therapy unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) p. 1015-1017.

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

Decision rationale: The ACOEM Guidelines indicate initial care includes the application of cold packs in the first few days of an acute complaint and thereafter, applications of a heat pack. The clinical documentation submitted for review failed to provide documentation of exceptional factors and failed to provide documentation the injured worker could not utilize at home applications of heat and cold. The request as submitted failed to indicate the body part to be treated, as well as whether the unit was for rental or purchase. Given the above, the request for cold/heat therapy unit is not medically necessary.

RTW-FCE testing: 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 chapter.

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 submitted for review failed to provide the injured worker had a failed attempt to return to work. Given the above, the request for RTW-FCE testing is not medically necessary.

VSNCT (Voltage-Actuated Sensory Nerve Conduction Threshold): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-pp-1021-1022.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back Chapter, Voltage actuated sensory nerve conduction (VSNCT), Current perception threshold (CPT) testing.

Decision rationale: The Official Disability Guidelines indicate that voltage actuated sensory nerve conduction testing is not recommended. There are no clinical studies demonstrating that quantitative testing of sensation improves the management and clinical outcomes of injured workers over standard qualitative methods of sensory testing. Given the above, the request for VSNCT (Voltage-Actuated Sensory Nerve Conduction Threshold) is not medically necessary.

DNA testing: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 42. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)-pain chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines cytokine testing Page(s): 42.

Decision rationale: The California MTUS Guidelines indicate that cytokine DNA testing for pain is not recommended. There was a lack of documentation of exceptional factors. The rationale was not provided. Given the above, the request for DNA testing is not medically necessary.