

Case Number:	CM15-0088467		
Date Assigned:	05/13/2015	Date of Injury:	03/08/2013
Decision Date:	06/19/2015	UR Denial Date:	04/14/2015
Priority:	Standard	Application Received:	05/08/2015

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: New York
Certification(s)/Specialty: Emergency Medicine

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 29 year old male who sustained a work related injury March 8, 2013. According to a primary treating physician's progress report, dated March 19, 2015, the injured worker presented with complaints of intermittent/moderate/throbbing low back pain, rated 5/10, with tingling and cramping. He also complains of constant moderate pain in the right foot, rated 6-7/10, described as dull/achy with numbness, tingling, and cramping, and radiating to the ankle and calf. Diagnoses are lumbar disc protrusion and right foot plantar fasciitis. Treatment plan included request for authorization for; physical therapy, pain management, podiatrist evaluation, compounded topical creams x2, Tramadol, and Protonix.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy 2x6: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

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

Decision rationale: CA MTUS chronic pain guidelines for manual therapy and manipulation are used in support of this decision. It is the assumed this request is for first time physical therapy

evaluation and treatment. Documentation does not support the IW has previously undergone such treatments. According to referenced guidelines, manual therapies are recommended for musculoskeletal conditions. A trial of 6 visits over 2 weeks with evidence of functional improvements. The request for 12 visits exceeds this recommendation. The request for 2x6 physical therapy sessions is not medically necessary.

Pain management for consideration of injections: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disabilities Guidelines, ACOEM 127.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter: office visit.

Decision rationale: CA MTUS is silent on this topic. According to ODG guidelines cited above, "The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible." The case materials reviewed do not support that referral for pain management evaluation for injections is warranted. There is no evidence in the chart to support neurologic findings, EMG testing or diagnostic studies of nerve impingement. Documentation does not support that treatment options within the current provider's scope of practice have been exhausted. The rationale for advanced evaluation is not understood from the submitted documentation. Without this supporting documentation, the request is not medically necessary.

Podiatrist evaluation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disabilities Guidelines, Acoem 127.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Foot and ankle chapter.

Decision rationale: The primary reason for this referral appears to be back pain as well tingling in the right foot. It is unclear from the records what the origin of the foot paresthesias is from. There is no documentation to support a diagnosis of ped planus. Additionally, foot tingling may be resultant from the treated back injury. There are no EMG studies included in the record to help determine the origin of the foot paresthesia. As podiatrist focus only on the foot and ankle and it is unclear that the origin of symptoms is from this area, the request for a podiatry evaluation is not medically necessary.

Gabapentin 10%, Amitriptyline 10%, Bupivacaine 5%-180gm: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

Decision rationale: CA MTUS chronic pain guidelines, topical analgesics are "largely experimental in use with few randomized controlled trials to determine efficacy or safety." Guidelines also state "Many agents are compounded as monotherapy or in combination for pain control. There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug that is not recommended is not recommended." One of the included compounds in the requested medication is Gabapentin. MTUS guidelines states that gabapentin is not recommended as there is no peer-reviewed literature to support its use. Additionally, the request does not include dosing frequency or duration. The request is not medically necessary.

Flurbiprofen 20%, Baclofen 10% Dexamethasone 2%-180gm: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesia Page(s): 111, 113.

Decision rationale: CA MTUS chronic pain guidelines, topical analgesics are "largely experimental in use with few randomized controlled trials to determine efficacy or safety." Guidelines also state "Many agents are compounded as monotherapy or in combination for pain control. There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug that is not recommended is not recommended." One of the included compounds in the requested medication is baclofen. MTUS guidelines states that baclofen is not recommended as there is no peer-reviewed literature to support its use. Additionally, the request does not include dosing frequency or duration. The request is not medically necessary.

Tramadol ER 100mg #45: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for neuropathic pain Page(s): 82-83.

Decision rationale: CA MTUS, chronic pain guidelines, offer very specific guidelines for the ongoing use of opiate pain medication to treat chronic pain. These recommendations state that the lowest possible dose be used as well as ongoing review and documentation of pain relief, functional status, appropriate medication use and its side effects. It also recommends that providers of opiate medication document the injured worker's response to pain medication including the duration of symptomatic relief, functional improvements, and the level of pain relief with the medications. Tramadol is recommended for the treatment of moderate to severe pain. It is not recommended as a first line agent for treatment. The chart materials do not include a list of all the analgesic medications currently used or the IW response to each medication. There is not discussion of the IW functional status in relation to the different medications. It is unclear how long the IW has been taking Tramadol. The chart does not include urine drug screens. With the absence of this supporting documentation, the request for Tramadol is not medically necessary.

Protonix 20mg #60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI symptoms & cardiovascular risk Page(s): 68-69.

Decision rationale: According to CA MTUS, gastrointestinal protectant agents are recommended for patients that are at increased risk for gastrointestinal events. These risks include age >65, history of gastrointestinal bleeding or peptic ulcers, concomitant use of NSAIDs and corticosteroids or aspirin, or high dose NSAID use. The chart does not document any of these risk factors. Past medical history does not include any gastrointestinal disorders, there is no history of poor tolerance to NSAIDs documented and there are not abdominal examinations noted in the chart. Protonix is not medically necessary based on the MTUS.