

<b>Case Number:</b>	CM14-0144528		
<b>Date Assigned:</b>	09/18/2014	<b>Date of Injury:</b>	03/17/2014
<b>Decision Date:</b>	11/13/2014	<b>UR Denial Date:</b>	08/29/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/05/2014

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Management and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a female patient with the date of injury of March 17, 2014. A Utilization Review was performed on August 29, 2014 and recommended non-certification of Flurbiprofen 20%, Tramadol 20%, 210g; Gabapentin 10%, amitriptyline 10%, dextromethorphan 10%, 210g; interferential unit; hot and cold unit; functional capacity evaluation; and physical therapy evaluation and treatments 2 times a week, for 6 weeks to the lumbar spine, left knee, and left wrist. A Doctor's First Report dated August 18, 2014 identifies Subjective Complaints of back, left wrist, and left knee pain. Objective Findings identify decreased range of motion (ROM) lumbosacral spine, tenderness to palpation bilateral paraspinal muscles/sacroiliac joints/sciatic notch/posterior iliac crest/gluteal muscles, muscle spasm bilateral paraspinal/gluteal muscles, palpable trigger points bilateral paraspinal muscles. Decreased ROM left dorsal wrist, large mass, and tenderness to palpation dorsal/palmar/ulnar/radial aspects. Decreased ROM left knee, medial knee swelling, tenderness to palpation laterally/medially, positive patella femoral grinding/McMurray test. Left knee flexor/extensor decreased motor strength at 4/5. Left anterolateral thigh decreased sensation to light touch and pinprick. Diagnoses identify thoracic musculoligamentous strain/sprain, lumbosacral musculoligamentous strain/sprain with radiculitis, large ganglion cyst left wrist aggravated by fall, left knee strain/sprain, rule out left knee internal derangement, rule out left knee meniscal tear. Treatment Rendered identifies prescriptions given for Flurbiprofen 20%, Tramadol 20%, 210g; Gabapentin 10%, amitriptyline 10%, dextromethorphan 10%, 210g; interferential unit; hot and cold unit; functional capacity evaluation; and physical therapy evaluation and treatments 2 times a week, for 6 weeks to the lumbar spine, left knee, and left wrist.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Compound Medication (Flurbiprofen 20% and Tramadol 20%, 210-grams): 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 Page(s): 111-113.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines state that any compounded product that contains at least one drug or drug class that is not recommended, is not recommended. Guidelines additionally state that topical NSAIDs are recommended for short-term use. Oral NSAIDs contain significantly more guideline support, provided there are no contraindications to the use of oral NSAIDs. Within the documentation available for review, there is no indication that the patient would be unable to tolerate oral NSAIDs, which would be preferred, or that the topical flurbiprofen is for short-term use, as recommended by guidelines. In the absence of clarity regarding those issues, the currently requested compound medication is not medically necessary.

**Compound Medication (Gabapentin 10%, Amitriptyline 10%, and Dextromethorphan 10%, 210-grams): 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 Page(s): 113.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines state that any compounded product that contains at least one drug or drug class that is not recommended, is not recommended. Guidelines additionally state that topical gabapentin is not recommended. They go on to state that there is no peer-reviewed literature to support its use. Therefore, in the absence of guideline support for the use of topical gabapentin, the currently requested compound medication is not medically necessary.

**An Interferential (IF) 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 Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines state that interferential current stimulation is not recommended as an isolated intervention. They go on to state that

patient selection criteria if interferential stimulation is to be used anyways include pain is ineffectively controlled due to diminished effectiveness of medication, side effects or history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercises, or unresponsive to conservative treatment. If those criteria are met, then in one month trial may be appropriate to study the effects and benefits. With identification of objective functional improvement, additional interferential unit use may be supported. Within the documentation available for review, there is no indication that the patient has met the selection criteria for interferential stimulation (pain is ineffectively controlled due to diminished effectiveness of medication, side effects or history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercises, or unresponsive to conservative treatment). In light of the above issues, the currently requested interferential unit is not medically necessary.

#### **A Hot & Cold Unit: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 1 Prevention. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Cold/Heat Packs

**Decision rationale:** The ACOEM Practice Guidelines state that various modalities such as heating have insufficient testing to determine their effectiveness, but they may have some value in the short term if used in conjunction with the program of functional restoration. The Official Disability Guidelines state that heat/cold packs are recommended as an option for acute pain. Within the documentation available for review, and there is no indication that the patient has acute pain. Additionally, it is unclear what program of functional restoration the patient is currently participating in which would be used alongside the currently requested hot & cold unit. In the absence of clarity regarding those issues, the currently requested hot & cold unit is not medically necessary.

#### **A Functional Capacity Evaluation (FCE): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 1 Prevention Page(s): 12. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Fitness for Duty Chapter, Functional Capacity Evaluation

**Decision rationale:** The ACOEM Practice Guidelines state that there is not good evidence that functional capacity evaluations are correlated with a lower frequency of health complaints or injuries. The Official Disability Guidelines state that functional capacity evaluations are recommended prior to admission to a work hardening program. The criteria for the use of a functional capacity evaluation includes case management being hampered by complex issues

such as prior unsuccessful return to work attempts, conflicting medical reporting on precautions and/or fitness for modified job, or injuries that require detailed explanation of a worker's abilities. Additionally, guidelines recommend that the patient be close to or at maximum medical improvement with all key medical reports secured and additional/secondary conditions clarified. Within the documentation available for review, there is no indication that there has been prior unsuccessful return to work attempts, conflicting medical reporting, or injuries that would require detailed exploration. In the absence of clarity regarding those issues, the currently requested functional capacity evaluation (FCE) is not medically necessary.

**Physical Therapy (evaluation and treatment, 2 times per week for 6 weeks for the lumbar spine): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298, Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Physical Therapy

**Decision rationale:** The 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. The Official Disability Guidelines (ODG) has more specific criteria for the ongoing use of physical therapy. The ODG recommends a trial of six physical therapy sessions. 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 no indication of any specific objective treatment goals and no statement indicating why an independent program of home exercise would be insufficient to address any objective deficits. Furthermore, the request exceeds the amount of physical therapy recommended by the California MTUS Guidelines and, unfortunately, there is no provision for modification of the current request. In the absence of such documentation, the current request for physical therapy is not medically necessary.

**Physical Therapy (evaluation and treatment, 2 times per week for 6 weeks for the left knee): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 337-338, Chronic Pain Treatment Guidelines Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee & Leg Chapter, Physical Therapy

**Decision rationale:** The 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. The Official Disability Guidelines (ODG) has more specific criteria for the ongoing use of physical therapy. The ODG recommends a trial of six physical therapy sessions. 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 no indication of any specific objective treatment goals and no statement indicating why an independent program of home exercise would be insufficient to address any objective deficits. Furthermore, the request exceeds the amount of PT recommended by the California MTUS Guidelines and, unfortunately, there is no provision for modification of the current request. In the absence of such documentation, the current request for physical therapy is not medically necessary.

**Physical Therapy (evaluation and treatment, 2 times per week for 6 weeks for the left wrist): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 265, Chronic Pain Treatment Guidelines Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm, Wrist, and Hand Chapter, Physical Therapy

**Decision rationale:** The 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. The Official Disability Guidelines (ODG) has more specific criteria for the ongoing use of physical therapy. The ODG recommends a trial of six physical therapy sessions. 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 no indication of any specific objective treatment goals and no statement indicating why an independent program of home exercise would be insufficient to address any objective deficits. Furthermore, the request exceeds the amount of PT recommended by the California MTUS Guidelines and, unfortunately, there is no provision for modification of the current request. In the absence of such documentation, the current request for physical therapy is not medically necessary.