

Case Number:	CM14-0148467		
Date Assigned:	10/23/2014	Date of Injury:	07/22/2011
Decision Date:	11/20/2014	UR Denial Date:	09/04/2014
Priority:	Standard	Application Received:	09/12/2014

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 Emergency Medicine, 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:

The injured worker is a 47 year-old female, who sustained an injury on July 22, 2011. The mechanism of injury occurred from lifting a bag of concrete. Diagnostics have included: Lumbar MRI (date not noted) reported as showing multi-level disc bulges. Treatments have included: medications, lumbar epidural injections. The current diagnoses are: thoraco-lumbar neuritis/radiculitis, hypertension, esophageal reflux, cervical and lumbar disc disease, cervical and lumbar strain/sprain, and the stated purpose of the request for Urinalysis for toxicology were not noted. The request for Urinalysis for toxicology was denied on September 4, 2014, citing a lack of documentation of aberrant drug behavior or risk factors. The stated purpose of the request for Functional capacity evaluation (FCE) was not noted. The request for Functional capacity evaluation (FCE) was denied on September 4, 2014, citing a lack of documentation of employer physical demand analysis. The stated purpose of the request for twelve sessions of chiropractic therapy was not noted. The request for twelve sessions of chiropractic therapy was denied on September 4, 2014, citing a lack of documentation of functional improvement from previous therapeutic interventions. The stated purpose of the request for Interferential Unit was not noted. The request for Interferential Unit was denied on September 4, 2014, citing a lack of documentation of functional improvement from previous use of electrical stimulation. The stated purpose of the request for Motorized cold therapy unit was not noted. The request for Motorized Cold Therapy Unit was denied on September 4, 2014, citing a lack of documentation of medical necessity for this unit versus simple hot and cold packs. The stated purpose of the request for Compound topical medication Flurbiprofen/Capsaicin/Camphor, 10/0.025%/2%/1% 120gm was not noted. The request for compound topical medication Flurbiprofen/ Capsaicin/ camphor, 10/0.025%/2%/1% 120gm was denied on September 4, 2014, citing a lack of documentation of intolerance to oral medications. The stated purpose of the request for Compounded topical

cream Ketoprofen/Cyclobenzaprine/Lidocaine, 10%/3%/5% 120gm was not noted. The request for Compounded topical cream Ketoprofen/Cyclobenzaprine/Lidocaine, 10%/3%/5% 120gm was denied on September 4, 2014, citing a lack of documentation of intolerance to oral medications. The stated purpose of the request for Tramadol 150mg #60 was not noted. The request for Tramadol 150mg #60 was denied on September 4, 2014, citing a lack of documentation of medical necessity for an opiate. The stated purpose of the request for Cyclobenzaprine 7.5mg #90 was not noted. The request for Cyclobenzaprine 7.5mg #90 was denied on September 4, 2014, citing a lack of documentation of an acute exacerbation or spasm on exam. Per the most recent report, date not noted, the treating physician noted complaints of land stiffness to the neck, pain to the low back. Exam findings included restricted cervical and lumbar range of motion, positive left-sided straight leg raising test. Per the June 20, 2014 report, the treating physician noted complaints of neck and back pain. Exam findings included cervical tenderness, full but painful cervical range of motion, lumbar tenderness with spasm and painful range of motion, decreased sensation to the right L4-5 dermatomes.

IMR ISSUES, DECISIONS AND RATIONALES

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

Urinalysis for toxicology: 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), Pain, Urine Drug Testing

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug testing" Page(s): 43.

Decision rationale: The requested Urinalysis for toxicology is not medically necessary. CA Medical Treatment Utilization Schedule (MTUS) 2009: Chronic Pain Treatment Guidelines, Page 43, "Drug testing", recommend drug screening "to assist in monitoring adherence to a prescription drug treatment regimen (including controlled substances); to diagnose substance misuse (abuse), addiction and/or other aberrant drug related behavior" when there is a clinical indication. These screenings should be done on a random basis. The injured worker has neck and low back pain. The treating physician has documented cervical tenderness, full but painful cervical range of motion, lumbar tenderness with spasm and painful range of motion, decreased sensation to the right L4-5 dermatomes, positive left-sided straight leg raising test. The treating provider has not documented provider concerns over patient use of illicit drugs or non-compliance with prescription medications. There is no documentation of the dates of neither the previous drug screening over the past 12 months nor what those results were and any potential related actions taken. The request for drug screening is to be made on a random basis. There is also no documentation regarding collection details, which drugs are to be assayed or the use of an MRO. The criteria noted above not having been met, Urinalysis for toxicology is not medically necessary.

Functional capacity evaluation (FCE): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Functional Capacity Evaluations Page(s): 125. Decision based on Non-MTUS Citation ACOEM Guidelines, Chapter 7, page 138

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-90.

Decision rationale: The requested Functional capacity evaluation (FCE) is not medically necessary. American College of Occupational Medicine, (ACOEM) Practice Guidelines, 2nd Edition (2004) Chapter 5, Cornerstones of Disability Prevention and Management, Reassessing Function and Functional Recovery, Page 89-90, note that there is little scientific evidence confirming FCE's ability to predict an individual's actual capacity to perform in the workplace, and are at least somewhat dependent on an evaluation of the employer's physical demand analysis. The injured worker has neck and low back pain. The treating physician has documented cervical tenderness, full but painful cervical range of motion, lumbar tenderness with spasm and painful range of motion, decreased sensation to the right L4-5 dermatomes, positive left-sided straight leg raising test. The treating physician has not documented that the injured worker is at Maximum Medical Improvement, nor documented the presence of a current and job-specific employer physical demand analysis. The criteria noted above not having been met, Functional capacity evaluation (FCE) is not medically necessary.

Twelve sessions of chiropractic therapy: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58.

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

Decision rationale: The requested twelve sessions of chiropractic therapy, is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Manual Therapy and Manipulation, Pages 58-59, recommend continued chiropractic therapy with documented objective evidence of derived functional benefit. The injured worker has neck and low back pain. The treating physician has documented cervical tenderness, full but painful cervical range of motion, lumbar tenderness with spasm and painful range of motion, decreased sensation to the right L4-5 dermatomes, positive left-sided straight leg raising test. The treating physician has not documented objective evidence of derived functional benefit from completed chiropractic sessions, such as improvements in activities of daily living, reduced work restrictions or reduced medical treatment dependence. Also, if this is the first use of chiropractic, or an exacerbation, the treating physician has not documented the medical necessity for additional sessions beyond the recommended six sessions for an acute trial. The criteria noted above not having been met, twelve sessions of Chiropractic Therapy is not medically necessary.

Interferential Unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300,Chronic Pain Treatment Guidelines Page(s): 118-120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy, Interferential current stimulation Page(s): 118-120.

Decision rationale: The requested Interferential Unit is not medically necessary. CA Chronic Pain Medical Treatment Guidelines, Transcutaneous electrotherapy, Interferential current stimulation, Page 118-120, noted that this treatment is "Not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone... There are no published randomized trials comparing TENS to Interferential current stimulation;" and the criteria for its use are: "Pain is ineffectively controlled due to diminished effectiveness of medications; or - Pain is ineffectively controlled with medications due to side effects; or - History of substance abuse; or - Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or - Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.)." The injured worker has neck and low back pain. The treating physician has documented cervical tenderness, full but painful cervical range of motion, lumbar tenderness with spasm and painful range of motion, decreased sensation to the right L4-5 dermatomes, positive left-sided straight leg raising test. The treating physician has not documented any of the criteria noted above, nor a current functional rehabilitation treatment program, nor derived functional improvement from electrical stimulation including under the supervision of a licensed physical therapist. The criteria noted above not having been met, Interferential Unit is not medically necessary.

Motorized cold therapy unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Hot/Cold packs

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 - Lumbar & Thoracic (Acute & Chronic)

Decision rationale: The requested Motorized cold therapy unit is not medically necessary. CA MTUS is silent and ODG Low Back - Lumbar & Thoracic (Acute & Chronic) note that hot and cold therapy is recommended during the acute phase of treatment. The injured worker has neck and low back pain. The treating physician has documented cervical tenderness, full but painful cervical range of motion, lumbar tenderness with spasm and painful range of motion, decreased sensation to the right L4-5 dermatomes, positive left-sided straight leg raising test. The treating physician has not documented the medical necessity for cold therapy beyond the acute phase of treatment. The criteria noted above not having been met, Motorized cold therapy unit is not medically necessary.

Compound topical medication Flurbiprofen/capsaicin/camphor, 10/0.025%/2%/1% 120gm:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

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

Decision rationale: The requested Compound topical medication Flurbiprofen/Capsaicin/Camphor, 10/0.025%/2%/1% 120gm, is not medically necessary. California Medical Treatment Utilization Schedule (MTUS), 2009, Chronic pain, page 111-113, Topical Analgesics, do not recommend topical analgesic creams as they are considered "highly experimental without proven efficacy and only recommended for the treatment of neuropathic pain after failed first-line therapy of antidepressants and anticonvulsants". The injured worker has neck and low back pain. The treating physician has documented cervical tenderness, full but painful cervical range of motion, lumbar tenderness with spasm and painful range of motion, decreased sensation to the right L4-5 dermatomes, positive left-sided straight leg raising test. The treating physician has not documented trials of anti-depressants or anti-convulsant. The treating physician has not documented intolerance to similar medications taken on an oral basis. The criteria noted above not having been met, Compound topical medication Flurbiprofen/Capsaicin/Camphor, 10/0.025%/2%/1% 120gm, is not medically necessary.

Compounded topical cream Ketoprofen/cyclobenzaprine/lidocaine, 10%/3%/5% 120gm:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

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

Decision rationale: The requested Compounded topical cream Ketoprofen/Cyclobenzaprine/Lidocaine, 10%/3%/5% 120gm, is not medically necessary. California Medical Treatment Utilization Schedule (MTUS), 2009, Chronic pain, page 111-113, Topical Analgesics, do not recommend topical analgesic creams as they are considered "highly experimental without proven efficacy and only recommended for the treatment of neuropathic pain after failed first-line therapy of antidepressants and anticonvulsants". The injured worker has neck and low back pain. The treating physician has documented cervical tenderness, full but painful cervical range of motion, lumbar tenderness with spasm and painful range of motion, decreased sensation to the right L4-5 dermatomes, positive left-sided straight leg raising test. The treating physician has not documented trials of anti-depressants or anti-convulsant. The treating physician has not documented intolerance to similar medications taken on an oral basis. The criteria noted above not having been met, Compounded topical cream Ketoprofen/Cyclobenzaprine/Lidocaine, 10%/3%/5% 120gm, is not medically necessary.

Tramadol 150mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 93-94.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-Going Management, Opioids for Chronic Pain, Tramadol Page(s): 78-80,80-82,113.

Decision rationale: The requested Tramadol 150mg #60 is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Opioids, On-Going Management, Pages 78-80, Opioids for Chronic Pain, Pages 80-82, and Tramadol, Page 113, do not recommend this synthetic opioid as first-line therapy, and recommend continued use of opiates for the treatment of moderate to severe pain, with documented objective evidence of derived functional benefit, as well as documented opiate surveillance measures. The injured worker has neck and low back pain. The treating physician has documented cervical tenderness, full but painful cervical range of motion, lumbar tenderness with spasm and painful range of motion, decreased sensation to the right L4-5 dermatomes, positive left-sided straight leg raising test. The treating physician has not documented: failed first-line opiate trials, VAS pain quantification with and without medications, nor measures of opiate surveillance including an executed narcotic pain contract nor urine drug screening. The criteria noted above not having been met, Tramadol 150mg #60 is not medically necessary.

Cyclobenzaprine 7.5mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63-64.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-66.

Decision rationale: The requested Cyclobenzaprine 7.5mg #90 is not medically necessary. CA MTUS Chronic Pain Treatment Guidelines, Muscle Relaxants, page 63-66, do not recommend muscle relaxants as more efficacious than NSAIDs and do not recommend use of muscle relaxants beyond the acute phase of treatment. The injured worker has neck and low back pain. The treating physician has documented cervical tenderness, full but painful cervical range of motion, lumbar tenderness with spasm and painful range of motion, decreased sensation to the right L4-5 dermatomes, positive left-sided straight leg raising test. The treating physician has not documented intolerance to NSAID treatment, nor medical necessity for use of a muscle relaxant beyond the acute phase of treatment. The criteria noted above not having been met, Cyclobenzaprine 7.5mg #90 is not medically necessary.