

Case Number:	CM15-0121585		
Date Assigned:	07/02/2015	Date of Injury:	12/08/2014
Decision Date:	09/04/2015	UR Denial Date:	06/16/2015
Priority:	Standard	Application Received:	06/23/2015

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: Arizona, Michigan

Certification(s)/Specialty: Preventive Medicine, Occupational 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 25 year old male, who sustained an industrial injury on 12/8/2014. He reported injury to the left ankle, back, right arm, right upper extremity, neck and psyche after falling. The injured worker was diagnosed as having neck muscle strain, contusion of face, scalp and neck, lumbar sprain/strain, lumbar spine myospasm and cervical spine myospasm. Treatment to date has included medications, physical therapy, and magnetic resonance imaging of the lumbar spine (2/18/2015), magnetic resonance imaging of the cervical spine (2/18/2015). The request is for Flurbiprofen 20%/Lidocaine 5%/Amitriptyline 5%, 180 gm; Trepadone #120, one (1) bottle; physical therapy evaluation & treatment; x-ray of the lumbosacral spine & left ankle; TENS unit purchase; and a functional capacity evaluation. Several physical therapy notes have been provided for this review. On 12/26/2014, he complained of back pain. He is taking motrin three times per day and Robaxin twice per day with a partial improvement noted. No side effects were noted. On 1/6/2015, a PR-2 indicated a modified work status. Non-steroidal anti-inflammatory drugs are noted to give no improvement. He complained of pain to his mid back, low back and neck, which he rated 8/10; and left foot pain he rated 4/10. On 1/12/2015, he complained of right neck pain rated 5-6/10, bilateral low back pain rated 7-8/10, left ankle/foot pain rated 0-4/10, and headache pain rated 5/10. He is noted to have limited ranges of motion of the cervical and lumbar spines. The treatment plan included: Cyclobenzaprine, and discontinuation of ibuprofen due to gastrointestinal nausea. On 2/16/2015, a PR-2 indicated subjective complaints noted as the injured working presenting himself to the office today, he is doing therapy, which is helping temporarily relieve pain. Physical findings revealed the cervical

spine range of motion/normal as 30/50 flexion, 40/60 extension, 65/80 right rotation, 65/80 left rotation, 30/45 right lateral flexion, 30/45 left lateral flexion; and lumbar spine range of motion/normal as 40/60 flexion, 20/25 extension, 10/25 right lateral bending, 10/25 left lateral bending. The treatment plan included topical compound for neuropathic pain, magnetic resonance imaging of the cervical spine and lumbar spine, Omeprazole, Naproxen, and a muscle relaxant. On 4/1/2015, the treatment plan included: request for a 30 day trial for a TENS unit, and a back brace. There were no noted subjective or objective findings on this progress report.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flurbiprofen 20%/Lidocaine 5%/Amitriptyline 5% 180gm: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, Topical analgesics.

Decision rationale: The CA MTUS guidelines do not recommend any compounded product that contains at least one drug (or drug class) that is not recommended. Flurbiprofen is considered to be an NSAID (non-steroidal anti-inflammatory drug). Topical compounds 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." Topical creams containing NSAIDs per MTUS may be recommended for short term for osteoarthritis and tendinitis. Topical NSAIDs are not recommended for osteoarthritis of the spine, hip, or shoulder. The MTUS guidelines indicate that Lidoderm is the only approved formulation of Lidocaine, and that no other commercially approved topical formulation of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. Amitriptyline is a tricyclic anti-depressant. Tricyclics are generally considered a first-line agent unless they are ineffective, poorly tolerated, or contraindicated. Antidepressants are recommended as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. The CA MTUS and ODG do not specifically address Amitriptyline as a topical agent. Therefore, there is no demonstrated medical necessity for topical amitriptyline. In this case, there is no documentation of the failure of conventional therapy, documented functional improvement, or recommendations for all the ingredients of the compound requested. Therefore, the request for Flurbiprofen 20%/Lidocaine 5%/Amitriptyline 5%, 180 gm is not medically necessary.

Trepadone #120: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter, Medical Foods, Trepadone.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, Medical foods.

Decision rationale: The CA MTUS does not specifically address Treadone. Per the ODG, Treadone is a medical food that is a proprietary blend of L-arginine, L-glutamine, choline bitartrate, L-serine and gamma-amino-butyric acid (GABA). It is intended for use in the management of joint disorders associated with pain and inflammation. Medical foods are not recommended for chronic pain. Medical foods are not recommended for the treatment of chronic pain as they have not been shown to produce meaningful benefits for improvements and functional outcomes. In this case, the documentation does not discuss the use of Treadone. The requested Treadone #120 does not indicate the dosing or frequency of use. Therefore, the requested Treadone #120 is not medically necessary.

Physical therapy evaluation and treatment to the cervical spine, thoracic spine, lumbar spine, right shoulder and left ankle, 3 times a week for 4 weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints, Chapter 12 Low Back Complaints, Chapter 14 Ankle and Foot Complaints Page(s): 174, 204, 299, 370, Chronic Pain Treatment Guidelines Introduction, Functional improvement; Physical medicine Page(s): 9, 98-99.

Decision rationale: Per the CA MTUS guidelines all therapies must be focused on the goal of functional restoration rather than merely the elimination of pain and assessment of treatment efficacy is accomplished by reporting functional improvement. Passive therapy is for the early phase of treatment. Active therapy is recommended over passive care, with transition to home therapy. The recommended quantities: myalgia and myositis, is 9-10 visits over 8 weeks; neuralgia, neuritis, and radiculitis is 8-10 visits over 4 weeks; and reflex sympathetic dystrophy (CRPS) it is 24 visits over 16 weeks. Functional improvement means either a clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical examination, performed and documented as part of the evaluation and management visit, and a reduction in the dependency on continued treatment. The documentation does not indicate that he was diagnosed with CRPS. Additionally, the documentation indicated he had completed an unknown number of physical therapy sessions and it is noted that he has gained temporary relief of pain with physical therapy. However there is no documentation to support the efficacy and outcome of the previous physical therapy sessions. Therefore the request for Physical therapy evaluation and treatment to the cervical spine, thoracic spine, lumbar spine, right shoulder and left ankle, 3 times a week for 4 weeks is not medically necessary.

X-ray of the lumbosacral spine and left ankle: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chapter 14 Ankle and Foot Complaints Page(s): 303, 373-374. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Ankle & Foot, Radiography.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chapter 14 Ankle and Foot Complaints Page(s): 289-310, 373-375.

Decision rationale: Per the CA MTUS guidelines, state that x-rays of the lumbar spine and ankle/foot should not be recommended in patients in the absence of red flags. A specific rationale as to why a lumbosacral spine or ankle/foot x-ray is not provided. The CA MTUS guidelines, support imaging studies with red flag conditions; physiologic evidence of tissue insult or neurologic dysfunction; failure to progress in a strengthening program intended to avoid surgery; clarification of the anatomy prior to an invasive procedure and definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. In this case, there is noted magnetic resonance imaging studies of the lumbar spine dated 2/18/2015. The documentation does not indicate any recent significant increase in symptomology or physical findings. Therefore, the request for x-ray of the lumbosacral spine and left ankle are not medically necessary.

TENS unit purchase: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-117.

Decision rationale: The CA MTUS guidelines state that transcutaneous electrotherapy is not recommended as a primary treatment modality, but a one month home-based transcutaneous electrical nerve stimulation (TENS) trial may be considered as a non-invasive option, if used as an adjunct to a program of evidence based functional restoration. There should be documentation of chronic intractable pain and evidence that other appropriate pain modalities have been tried and failed. A one month trial should be documented with evidence of how often the unit was used, as well as outcomes in terms of pain relief and function. In this case, the documentation indicated that a 30 day trial of a TENS unit was requested; however there is no evidence of short term and long term goals, or failure to respond to appropriate pain modalities prior to the request for a TENS unit. In addition, the documentation does not indicate the pain relief, and outcomes of a 30 day TENS unit trial. Therefore, the request for the TENS unit purchase is not medically necessary.

Functional capacity evaluation-physical performance: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Fitness for Duty Chapter, Functional Capacity Evaluation.

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, Functional Capacity Evaluation.

Decision rationale: The CA MTUS guidelines state that a number of functional assessment tools are available, including functional capacity evaluations when reassessing function and functional recovery. The ODG guidelines do not recommend proceeding with a functional capacity evaluation if the sole purpose is to determine a worker's effort or compliance and/or if the worker has returned to work without having an ergonomic assessment arranged. The request of functional capacity evaluation - physical performance indicates that in this case this evaluation would be for the purpose of determining a worker's effort or compliance or to document his current physical abilities. There is no evidence in the documentation to support there is a previous failure to return to work, or return to modified duty work or that the evaluation is not for the sole purpose of determining his effort. Therefore, the request for functional capacity evaluation - physical performance is not medically necessary.