MAXIMUS Federal Services

Case Number:	CM15-0176876		
Date Assigned:	09/28/2015	Date of Injury:	07/08/2015
Decision Date:	12/17/2015	UR Denial Date:	08/27/2015
Priority:	Standard	Application Received:	09/08/2015

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: California
Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 7-8-2015. The injured worker was being treated for lumbar musculoligamentous injury, lumbar sprain and strain, right knee sprain and strain, right foot bursitis, and right foot pain. On 7-31-2015, the injured worker reported intermittent lumbar pain and stiffness, rated 4 out of 10. He reported right knee pain and stiffness. He also reported right foot pain and stiffness, which is rated 8 out of 10. The physical exam (7-31-2015) revealed decreased lumbar range of motion and tenderness to palpation and spasms of the paravertebral muscles. The right knee flexion and extension were normal. There was tenderness to palpation of the medial knee and pain caused by McMurray's. There was normal range of motion of the right foot, tenderness to palpation of the fourth and fifth metatarsals, and pain caused by carpal compression. Treatment has included chiropractic therapy with electrical stimulation. Per the treating physician (7-31-2015 report), the injured worker was placed on temporarily totally disabled. On 7-31-2015, the requested treatments included Capsaicin-Flurbiprofen-Gabapentin-Menthol-Camphor topical compound 180 gms, Gabapentin-Amitriptyline-Dextromethorphan topical compound 180 gms, a knee brace right knee indefinite use, transcutaneous electrical nerve stimulation-electrical muscle stimulation (TENS/EMS) unit, DNA testing, x-rays of the lumbar spine, x-rays of the right foot, 12 acupuncture sessions for the lumbar spine, 12 sessions of physiotherapy right knee and right foot, Omeprazole 20mg #60, and Cyclobenzaprine 10mg #60. On 8-27-2015, the original utilization review non-certified requests for Capsaicin-Flurbiprofen-Gabapentin-Menthol-Camphor topical compound 180 gms, Gabapentin-Amitriptyline-Dextromethorphan topical compound 180 gms, a knee brace right knee indefinite use, transcutaneous electrical nerve

stimulation-electrical muscle stimulation (TENS/EMS) unit, DNA testing, x-rays of the lumbar spine, x-rays of the right foot, and Cyclobenzaprine 10mg #60. On 9-9-2015, the original utilization review modified requests for 12 acupuncture sessions for the lumbar spine, 12 sessions of physiotherapy right knee and right foot, and Omeprazole 20mg #60.

IMR ISSUES, DECISIONS AND RATIONALES

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

Capsaicin/Flurbiprofen/Gabapentin/Menthol/Camphor topical compound 180 gms: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: Regarding the request for Capsaicin/Flurbiprofen/Gabapentin/Menthol/ Camphor topical compound 180 gms, CA MTUS states that topical compound medications require guideline support for all components of the compound in order for the compound to be approved. Regarding topical gabapentin, Chronic Pain Medical Treatment Guidelines state that topical anti-epileptic medications are not recommended. They go on to state that there is no peer-reviewed literature to support their use. As such, the currently requested Capsaicin/ Flurbiprofen/Gabapentin/Menthol/Camphor topical compound 180 gms is not medically necessary.

Gabapentin/Amitriptyline/Dextromethorphan topical compound 180 gms: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: Regarding the request for Gabapentin/Amitriptyline/Dextromethorphan topical compound 180 gms, CA MTUS states that topical compound medications require guideline support for all components of the compound in order for the compound to be approved. Regarding topical gabapentin, Chronic Pain Medical Treatment Guidelines state that topical anti- epileptic medications are not recommended. They go on to state that there is no peer-reviewed literature to support their use. Guidelines do not support the use of topical antidepressants. As such, the currently requested Gabapentin/Amitriptyline/Dextromethorphan topical compound 180 gms is not medically necessary.

Knee brace right knee indefinite use: Upheld

Claims Administrator guideline: Decision based on MTUS Knee Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee & Leg, Knee Brace.

MAXIMUS guideline: Decision based on MTUS Knee Complaints 2004, Section(s): Initial Care. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee Chapter, Knee brace.

Decision rationale: Regarding the request for a knee brace, Occupational Medicine Practice Guidelines state that a brace can be used for patellar instability, anterior cruciate ligament tear, or medial collateral ligament instability although its benefits may be more emotional than medical. Usually a brace is necessary only if the patient is going to be stressing the knee under load, such as climbing ladders or carrying boxes. For the average patient, using a brace is usually unnecessary. ODG recommends valgus knee braces for knee osteoarthritis. ODG also supports the use of knee braces for knee instability, ligament insufficiency, reconstructed ligament, articular defect repair, avascular necrosis, meniscal cartilage repair, painful failed total knee arthroplasty, painful high tibial osteotomy, painful unicompartmental osteoarthritis, and tibial plateau fracture. Within the documentation available for review, there is no indication that the patient has any of the diagnoses for which a knee brace is indicated, or any indication that the patient will be stressing the knee under load. In the absence of such documentation, the currently requested knee brace is not medically necessary.

TENS/EMS unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Electrical stimulators (E-stim).

Decision rationale: Regarding the request for TENS/EMS unit, this unit is a combination electrical stimulation unit which includes TENS and neuromuscular stimulation. In order for a combination device to be supported, there needs to be guideline support for all incorporated modalities. Chronic Pain Medical Treatment Guidelines state that TENS is not recommended as a primary treatment modality, but a one month home-based TENS trial may be considered as a noninvasive conservative option if used as an adjunct to a program of evidence-based functional restoration. Additionally, guidelines state that neuromuscular electrical stimulation is not recommended. Within the documentation available for review, there is no indication that the patient is undergone a 30 day TENS unit trial as recommended by guidelines. Additionally, guidelines do not support the use of neuromuscular stimulation. As such, the currently requested TENS/EMS unit is not medically necessary.

DNA 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.

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, Cytokine DNA Testing, Genetic testing for Potential Opioid Abuse.

Decision rationale: Regarding a request for DNA test, California MTUS and ACOEM do not contain criteria for this request. ODG states that cytokine DNA testing is not recommended. Additionally, they state that genetic testing for potential opioid abuse is not recommended. As such, the currently requested DNA test is not medically necessary.

X-ray lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Radiography (X-rays).

Decision rationale: Regarding request for lumbar spine x-ray, Occupational Medicine Practice Guidelines state that x-rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology even if the pain has persisted for at least 6 weeks. However, it may be appropriate when the physician believes it would aid in patient management. Guidelines go on to state that subsequent imaging should be based on new symptoms or a change in current symptoms. Within the documentation available for review, there is no identification of any red flag diagnoses. Additionally, there is no documentation of failed conservative treatment prior to the request for imaging nor is there any identification indicating how the medical decision-making will be changed based upon the outcome of the currently requested lumbar x-ray. In the absence of clarity regarding those issues, the currently requested lumbar x-ray is not medically necessary.

X-rays right foot: Upheld

Claims Administrator guideline: Decision based on MTUS Ankle and Foot Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Ankle & Foot, Radiography.

MAXIMUS guideline: Decision based on MTUS Ankle and Foot Complaints 2004, Section(s): Special Studies.

Decision rationale: Regarding the request for x-ray of the ankle, ACOEM guidelines state that special studies are not needed to evaluate most complaints until after a period of conservative care and observation. Within the documentation available for review, there is notification of any red flag diagnoses. Additionally, there is no documentation of failed conservative treatment prior to the request for imaging nor is there any identification indicating how the medical decision- making will be changed based upon the outcome of the currently requested right x-ray. In the absence of clarity regarding those issues, the currently requested repeat x-ray of the ankle is not medically necessary.

12 Acupuncture sessions lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment 2007.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment 2007. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Acupuncture.

Decision rationale: Regarding the request for acupuncture, California MTUS does support the use of acupuncture for chronic pain. Acupuncture is recommended to be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Additional use is supported when there is functional improvement documented, which is defined as "either a clinically significant improvement in activities of daily living or a reduction in work restrictions and a reduction in the dependency on continued medical treatment." A trial of up to 6 sessions is recommended, with up to 24 total sessions supported when there is ongoing evidence of functional improvement. Within the documentation available for review, it is unclear what current concurrent rehabilitative exercises will be used alongside the requested acupuncture. Additionally, the current request for 12 visits exceeds the 6 visit trial recommended by guidelines. Unfortunately, there is no provision to modify the current request. As such, the currently requested acupuncture is not medically necessary.

12 sessions of Physio therapy right knee, right foot: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Ankle & Foot Chapter, Physical Therapy.

Decision rationale: Regarding the request for physical therapy, 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. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. 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 ODG as a trial 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.

Omeprazole 20mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steriodal anti-inflammatory drugs), NSAIDs, GI symptoms & cardiovascular risk, NSAIDs, hypertension and renal function, NSAIDs, specific drug list & adverse effects. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Proton Pump Inhibitors (PPIs).

Decision rationale: Regarding the request for omeprazole (Prilosec), California MTUS states that proton pump inhibitors are appropriate for the treatment of dyspepsia secondary to NSAID therapy or for patients at risk for gastrointestinal events with NSAID use. Within the documentation available for review, there is no indication that the patient has complaints of dyspepsia secondary to NSAID use, a risk for gastrointestinal events with NSAID use, or another indication for this medication. In light of the above issues, the currently requested omeprazole (Prilosec) is not medically necessary.

Cyclobenzaprine 10mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

Decision rationale: Regarding the request for cyclobenzaprine (Flexeril), Chronic Pain Medical Treatment Guidelines support the use of non-sedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Guidelines go on to state that cyclobenzaprine specifically is recommended for a short course of therapy. Within the documentation available for review, there is no identification of a specific analgesic benefit or objective functional improvement as a result of the cyclobenzaprine. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. Finally, there is no documentation of failure of first-line treatment options, as recommended by guidelines. In the absence of such documentation, the currently requested cyclobenzaprine (Flexeril) is not medically necessary.