

Case Number:	CM15-0179840		
Date Assigned:	09/28/2015	Date of Injury:	07/29/2013
Decision Date:	11/25/2015	UR Denial Date:	08/20/2015
Priority:	Standard	Application Received:	09/14/2015

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: Internal 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 52 year old female who sustained an industrial injury on 7-29-13. Diagnoses are noted as bilateral knee sprain-strain, rule out bilateral knee internal derangement, and rule out bilateral knee meniscus tear. Previous treatment includes medication, lumbar spine support, knee braces, extracorporeal shockwave therapy-cervical spine, left shoulder and knees, functional capacity evaluation, (LINT) localized intense neurostimulation therapy, and acupuncture. In a doctor's first report of occupational injury or illness dated 8-5-15, the physician notes subjective complaints of headaches, bilateral knee pain, depression and sleeping problems. The objective findings are that she ambulates with an antalgic gait favoring the left lower extremity, there is bilateral knee swelling, tenderness to palpation, decreased range of motion, positive patellofemoral grinding and positive McMurray's test bilaterally, left knee varus deformity and decreased motor strength of the knees at 4 out of 5. Urine toxicology was noted as being administered this visit for medication monitoring. Work status is total temporary disability until 9-16-15. A request for authorization is dated 8-5-15. The requested treatment of interferential unit, MRI bilateral knees, urine toxicology screen, Tramadol 50mg #60, Theramine #90, Flurbi (NAP) Cream LA: Flurbiprofen 20%-Lidocaine 5%-Amitriptyline 5% 180 grams, hypnotherapy evaluation and treatment 1x4, and acupuncture evaluation and treatment 2x6 was non-certified on 8-20-15.

IMR ISSUES, DECISIONS AND RATIONALES

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

IF Unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation ODG Pain Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter- Knee & Leg (Acute & Chronic) Interferential current therapy (IFC).

Decision rationale: As per Official Disability Guidelines (ODG) Interferential current therapy (IFC) is under study for osteoarthritis and recovery post knee surgery. Not recommended for chronic pain or low back problems. After knee surgery, home interferential current therapy (IFC) may help reduce pain, pain medication taken, and swelling while increasing range of motion, resulting in quicker return to activities of daily living and athletic activities. Based on the currently available information in the submitted Medical Records of this injured worker, and per review of the guidelines, the medical necessity for Interferential Current Stimulation (ICS) unit has not been established. Requested Treatment for Interferential Current Stimulation (ICS) is not medically necessary.

MRI Bilateral Knees: Upheld

Claims Administrator guideline: Decision based on MTUS Knee Complaints 2004. Decision based on Non-MTUS Citation ODG Knee & Leg Chapter.

MAXIMUS guideline: Decision based on MTUS Knee Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee Chapter--MRIs (magnetic resonance imaging).

Decision rationale: California MTUS Guidelines state Special studies are not needed to evaluate most knee complaints until after a period of conservative care and observation. Reliance only on imaging studies to evaluate the source of knee symptoms may carry a significant risk of diagnostic confusion (false-positive test results) because of the possibility of identifying a problem that was present before symptoms began, and therefore has no temporal association with the current symptoms. Official Disability Guidelines (ODG) recommend MRI (magnetic resonance imaging) of Knee for; 1) Acute trauma to the knee, including significant trauma (e.g, motor vehicle accident), or if suspect posterior knee dislocation or ligament or cartilage disruption. 2) Non-traumatic knee pain, child or adolescent: nonpatellofemoral symptoms. Initial anteroposterior and lateral radiographs nondiagnostic (demonstrate normal findings or a joint effusion) next study if clinically indicated. 3) Repeat MRIs: Post-surgical if need to assess knee cartilage repair tissue. Routine use of MRI for follow-up of asymptomatic patients following knee arthroplasty is not recommended. The records do not indicate any significant change in this injured worker's symptoms. In the submitted medical records of injured worker, no information about prior imaging reports can be found. Without such information, determination cannot be made, therefore, the requested treatment: MRI Bilateral Knees is not medically necessary.

Urine Toxicology Screen: 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): Drug testing.

Decision rationale: Per the CA MTUS, drug testing is recommended as an option, using a urine drug screen to assess for the use or the presence of illegal drugs. The CA MTUS recommends in on-going opioid management, drug screening or inpatient treatment for those patients with issues of abuse, addiction, or poor pain control, along with documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion). In this case, there is no discussion of abuse, addiction, or misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion). In addition, the request for Tramadol has been determined to be not medically necessary. Therefore, the request for Urine Drug Toxicology Screen is not medically necessary.

Tramadol 50mg #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): Opioids, California Controlled Substance Utilization Review and Evaluation System (CURES) [DWC], Opioids for chronic pain.

Decision rationale: The California MTUS Chronic Pain Medical Treatment guidelines recommend specific guidelines for the ongoing use of narcotic pain medication to treat chronic pain. "Recommendations include 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." The documentation submitted did not include functional improvement with the use of this medication. Functional improvement is defined as a decrease in work restrictions or improvement in activities of daily living, plus decreased dependence on medical treatment. There was no documentation of definite return to work or decrease in work restrictions, no specific improvement in activities of daily living as a result of use of Tramadol, Therefore the request for Tramadol 50mg #60 is not medically necessary.

Theramine #90: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Pain Chapter.

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

Decision rationale: ODG state that dietary supplements/ vitamins are intended for specific dietary management of disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation. ODG state that medical food is not recommended. Medical food is a food which is formulated to be consumed or administered entirely under the supervision of a physician and which is intended for specific dietary management of disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation. Official Disability Guidelines (ODG) does not recommend Theramine for the treatment of chronic pain. Theramine is a medical food that contains 5-hydroxytryptophan 95%, choline bitartrate, L-arginine, histidine, L-glutamine, L-serine, gamma-aminobutyric acid (GABA), whey protein concentrates, grape seed extract 85%, cinnamon, and cocoa (theobromine 6%). The entries for 5-hydroxytryptophan, choline bitartrate, L-arginine, histidine, L-glutamine, L-serine and GABA are given and all indicate there is no role for these supplements as treatment for chronic pain. Review of medical records neither mentions any rationale, nor any documentation of deficiency. Request does not specify frequency. Based on the currently available information and per review of guidelines, the medical necessity for Theramine has not been established. The requested treatment is not medically necessary.

Flurbi (NAP) Cream LA: Flurbiprofen 20%, Lidocaine 5%, Amitriptyline 5% 180 grams:
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 based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter--Lidoderm® (lidocaine patch).

Decision rationale: Per the CA MTUS guidelines, although recommended as an option, topical analgesics are used primarily for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Furthermore, they are largely experimental. Flurbiprofen is used as a topical NSAID. It has been shown in a meta-analysis to be superior to placebo during the first two weeks of treatment for osteoarthritis but either, not afterward, or with diminishing effect over another two-week period. There are no clinical studies to support the safety or effectiveness of Flurbiprofen in a topical delivery system (excluding ophthalmic). As per ODG, Lidoderm patches are not a first-line treatment and are only FDA approved for post-herpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. As per MTUS, "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." In this case, there is no documentation that this patient has tried taking antidepressants and/or anticonvulsants." Based on the currently available information in the submitted Medical Records of this injured worker, and per review of the guidelines, the medical necessity for requested treatment: Flurbi (NAP) Cream LA: Flurbiprofen 20%, Lidocaine 5%, Amitriptyline 5% 180 grams has not been established, therefore is not medically necessary.

Hypnotherapy evaluation and treatment 1x4: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Mental Illness & Stress Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Mental Illness & Stress Chapter-- Hypnosis.

Decision rationale: As per Official Disability Guidelines (ODG) Criteria for the use of Hypnosis: Providers: Hypnosis should only be used by credentialed health care professionals, who are properly trained in the clinical use of hypnosis and are working within the areas of their professional expertise. Indications: There are a number of indications for using hypnosis in the treatment of PTSD: (1) Hypnotic techniques may be especially valuable for symptoms often associated with PTSD, such as dissociation and nightmares, for which they have been successfully used; (2) PTSD patients who manifest at least moderate hypnotizability may benefit from the addition of hypnotic techniques to their treatment; (3) Because confronting traumatic memories may be very difficult for some PTSD patients, hypnotic techniques may provide them with a means to modulate the emotional and cognitive distance from such memories as they are worked through therapeutically. Contraindications: There are a number of contraindications for using traditional hypnotic techniques in the treatment of PTSD: (1) In the rare cases of individuals who are refractory or minimally responsive to suggestions, hypnotic techniques may not be the best choice, because there is some evidence that hypnotizability is related to treatment outcome efficacy; (2) Some PTSD patients may be reluctant to undergo hypnosis, either because of religious belief or other reasons. If the resistance is not cleared after dispelling mistaken assumptions, other suggestive techniques can be tried, including emotional self-regulation therapy (ESRT), which is done with open eyes and uses sensory recall exercises rather than a hypnotic induction; (3) For patients who have low blood pressure or are prone to fall asleep, hypnotic procedures such as alert hand, which emphasize alertness and activity rather than relaxation, may be substituted. The notes submitted by treating provider do not give details for the need of this request. Given the lack of documentation and considering the given guidelines, the request is not medically necessary.

Acupuncture evaluation and treatment 2x6: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment 2007.

Decision rationale: This prescription for acupuncture is evaluated in light of the MTUS recommendations for acupuncture. The MTUS recommends an initial trial of 3-6 visits of acupuncture. Per the MTUS, acupuncture is used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical

intervention to hasten functional recovery. Medical necessity for any further acupuncture is considered in light of functional improvement. There is evidence that this injured worker has received treatment with acupuncture before, however the records are not clear about its functional benefits. There was no discussion by the treating physician regarding a decrease or intolerance to pain medications. Also 12 visits of acupuncture exceed the MTUS recommendation. Given the MTUS recommendations for use of acupuncture, the requested treatment Acupuncture evaluation and treatment 2x6 is not medically necessary.