

Case Number:	CM15-0035683		
Date Assigned:	04/08/2015	Date of Injury:	09/16/2014
Decision Date:	05/07/2015	UR Denial Date:	01/28/2015
Priority:	Standard	Application Received:	02/25/2015

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: Massachusetts

Certification(s)/Specialty: Anesthesiology, 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 32-year-old female who sustained an industrial injury on 09/18/14. Initial complaints and diagnoses are not available. Treatments to date include medications, physical therapy and acupuncture. Diagnostic studies are not addressed. Current complaints include pain in the right hand, wrist and shoulder, as well as the neck and upper back. In a progress note dated 03/18/15 the treating provider reports the plan of care as medications including flexeril, ibuprofen, topical creams, acupuncture, physical therapy, and chiropractic treatments, extracorporeal shock wave treatments, Voltage-Actuated Sensory Nerve Conduction Threshold testing for the thoracic spine, MRIs of the cervical and thoracic spine, and right shoulder and wrist, and psychological evaluation and a Functional Capacity Evaluation. The requested treatments are 2 topical creams, a TENS unit, DNA testing, urinalysis, x-rays of the cervical and thoracic spine, right shoulder and wrist, and acupuncture, chiropractic treatments, and physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Capsaicin 0.025%, Flurbiprofen 15%, Gabapentin 10%, Menthol 2%, Camphor 2%, 180gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111, 113. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic), Salicylate topicals.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topicals Page(s): 111.

Decision rationale: According to the MTUS, there is little to no research to support the use of topical compounded creams. It also contains menthol, a non-recommended topical agent. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. Topical analgesics are largely experimental and there are a few randomized controlled trials to determine efficacy or safety. Therefore, at this time, the requirements for treatment have not been met and is not medically necessary.

Gabapentin 15%, Amitriptyline 4%, Dextromethorphan 10%, 180gm: 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 Topicals Page(s): 111.

Decision rationale: According to the MTUS, there is little to no research to support the use of topical compounded creams. It also contains menthol, a non-recommended topical agent. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. Topical analgesics are largely experimental and there are a few randomized controlled trials to determine efficacy or safety. Therefore, at this time, the requirements for treatment have not been met and is not medically necessary.

DME - TENS/EMS Unit QTY: 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation), Criteria for use of TENS Page(s): 114, 116.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 114.

Decision rationale: TENS, chronic pain (transcutaneous electrical nerve stimulation), p114 According to the MTUS, 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 for the conditions described

below: a home based treatment trial of one month may be appropriate for neuropathic pain and CRPS II, CRPS I, neuropathic pain, phantom limb pain, spasticity, multiple sclerosis. According to the documents available for review, injured worker has none of the MTUS / recommended indications for the use of a TENS unit. Therefore, at this time the requirements for treatment have not been met, and are not medically necessary.

DNA Testing QTY: 1: 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 (Chronic), Genetic testing for opioid abuse.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment.

Decision rationale: The ACOEM Chapter 3 on Initial Approaches to Treatment indicates that specialized treatments or referrals require a rationale for their use. According to the documents available for review, there is no rationale provided to support the use of a DNA test. Therefore, at this time the requirements for treatment have not been met, and is not medically necessary.

Urine Analysis Testing QTY: 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of Opioids.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Pain (Chronic), Drug Testing.

Decision rationale: Recommended as a tool to monitor compliance with prescribed substances, identify use of undisclosed substances, and uncover diversion of prescribed substances. The test should be used in conjunction with other clinical information when decisions are to be made to continue, adjust or discontinue treatment. This information includes clinical observation, results of addiction screening, pill counts, and prescription drug monitoring reports. The prescribing clinician should also pay close attention to information provided by family members, other providers and pharmacy personnel. State and local laws may dictate the frequency of urine drug testing. According to the documents available for review, the injured worker meets none of the aforementioned MTUS criteria for the use of urine drug testing. Therefore, at this time the requirements for treatment have not been met, and are not medically necessary at this time.

X-Ray for the Cervical Spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

Decision rationale: The ACOEM Chapter 8 on Neck indicates that specialized treatments or referrals require a rationale for their use. According to the documents available for review, there is no rationale provided to support the request for a cervical spine x-ray. Therefore, at this time the requirements for treatment have not been met, and are not medically necessary at this time.

X-Ray for the Thoracic Spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

Decision rationale: The ACOEM Chapter 8 on Neck and Upper Back indicates that specialized treatments or referrals require a rationale for their use. According to the documents available for review, there is no rationale provided to support the request for a thoracic spine x-ray. Therefore, at this time the requirements for treatment have not been met, and are not medically necessary at this time.

X-Ray for the Right Shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

Decision rationale: The ACOEM Chapter 9 on Shoulder indicates that specialized treatments or referrals require a rationale for their use. According to the documents available for review, there is no rationale provided to support the request for a shoulder x-ray. Therefore, at this time the requirements for treatment have not been met, and are not medically necessary at this time.

X-Ray for the Right Wrist: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

Decision rationale: The ACOEM Chapter 11 on Wrist indicates that specialized treatments or referrals require a rationale for their use. According to the documents available for review, there is no rationale provided to support the request for a wrist x-ray. Therefore, at this time the requirements for treatment have not been met, and are not medically necessary at this time.

Acupuncture for the Cervical Spine, Thoracic Spine, Right Shoulder, and Right Wrist
QTY: 6: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: 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 is a functional recovery. Time to produce functional improvement is 3 to 6 treatments, frequency 1 to 3 times per week, optimum duration 1 to 2 months. Acupuncture treatments may be extended a functional improvement is documented. According to the documents available for review, the IW previously underwent several sessions of acupuncture without documented functional improvement. Therefore, at this time the requirements for treatment have not been met, and are not medically necessary at this time.

Chiropractic for the Cervical Spine, Thoracic Spine, Right Shoulder, and Right Wrist
QTY: 12: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back (Acute & Chronic), Manipulation, Chiropractic Guidelines; Shoulder (Acute & Chronic), Chiropractic.

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

Decision rationale: According to the MTUS section on manual therapy and manipulation, manual therapy is recommended for chronic pain if caused by musculoskeletal conditions. In addition, initial trial of six visits over two weeks is advised. Further sessions, up to a total of 18 visits, is appropriate with evidence of objective functional improvement. In addition, initial request of 12 sessions is in contrast to the treatment recommendations as outlined in the MTUS. Therefore, at this time the requirements for treatment have not been met, is not medically necessary at this time.

Physio Therapy for the Cervical Spine, Thoracic Spine, Right Shoulder, and Right Wrist
QTY: 12: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back (Acute & Chronic), Physical Therapy; Shoulder (Acute & Chronic), Physical Therapy; Forearm, Wrist and Hand (Acute & Chronic), Physical/Occupational Therapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98.

Decision rationale: Physical Medicine is recommended as indicated below. Passive therapy (those treatment modalities that do not require energy expenditure on the part of the injured worker) can provide short-term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Injured workers are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. (Colorado, 2002) (Airaksinen, 2006) Injured worker-specific hand therapy is very important in reducing swelling, decreasing pain, and improving range of motion in CRPS. (Li, 2005) The use of active treatment modalities (e.g., exercise, education, activity modification) instead of passive treatments is associated with substantially better clinical outcomes. In a large case series of injured workers with low back pain treated by physical therapists, those adhering to guidelines for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. The overall success rates were 64.7% among those adhering to the active treatment recommendations versus 36.5% for passive treatment. (Fritz, 2007) Physical Medicine Guidelines: Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks, Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2) 8-10 visits over 4 weeks, Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks. According to the documents available for review, the injured worker has previously undergone numerous sessions of PT without objective documented functional improvement. Further sessions of PT would be in contrast to the guidelines as set forth in the MTUS. Therefore, at this time, the requirements for treatment have not been met and is not medically necessary at this time.