

Case Number:	CM15-0045690		
Date Assigned:	04/14/2015	Date of Injury:	06/30/2014
Decision Date:	05/28/2015	UR Denial Date:	02/27/2015
Priority:	Standard	Application Received:	03/10/2015

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

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 06/30/2014. The injured worker reported an industrial injury while pulling products off of an assembly line. A crush injury to the bilateral feet was also documented. Diagnoses included lumbar sprain, sprain of unspecified site of right elbow, sprain of unspecified site of right wrist/hand, sprain of other specified sites of left hip and thigh and left ankle/foot injury. Treatment to date has included x-rays, chiropractic care, acupuncture, MRI and medications. The injured worker presented on 01/16/2015 for a follow-up evaluation. The injured worker reported persistent pain over multiple areas of the body. There was also numbness and tingling reported. Upon examination of the elbow and forearm, there was nonspecific tenderness at the right elbow with mild tenderness at the medial and lateral epicondyle. There was normal range of motion of the right upper extremity. Examination of the wrist revealed nonspecific tenderness on the right as well as carpal tunnel tenderness. There was normal range of motion of the right wrist. Examination of the cervical spine revealed normal deep tendon reflexes, 5/5 motor strength, and hypoesthesia in the right C6 through T1 dermatomes. There was moderate paraspinal tenderness and spasm at the T6-L1 levels. There was also tenderness to palpation with bilateral muscle spasm at T12-S1. Lumbar range of motion was noted at 50 degree flexion, 15 degree extension, and 10 degree left and right lateral bending. There was tenderness at the left thigh and hip as well as the greater trochanteric region, iliotibial band on the left, and nonspecific tenderness at the left ankle. Treatment recommendations at that time included laboratory testing, a sleep study, a toxicology test, a multi stimulator unit, an aqua relief system, an MRI of the thoracic

and lumbar spine, an MRI of the left ankle, electrodiagnostic studies, acupuncture treatment, and prescriptions for omeprazole, tramadol, cyclobenzaprine, Theramine, Sentra PM, Sentra AM, Terocin patch, and 2 compounded creams. There was no Request for Authorization form submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of Left Ankle: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 372-374.

Decision rationale: The California MTUS/ACOEM Practice Guidelines state for most cases presenting with true foot and ankle disorders, special studies are usually not needed until after a period of conservative care and observation. It is noted that the injured worker suffered a crush injury to the bilateral lower extremities, and reports left foot pain with radiation into the ankle and leg. However, the physical examination only revealed nonspecific tenderness. There is no documentation of a significant functional deficit involving the left ankle. There are no mechanical symptoms noted. There is also little evidence of failed conservative treatment with regard to the left ankle. Given the above, the request is not medically necessary.

MRI of Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: The California MTUS/ACOEM Practice Guidelines state if physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test. In this case, there is no documentation of a significant functional deficit upon examination. There is no evidence of a motor or sensory deficit. There is little evidence regarding conservative treatment prior to the request for an imaging study. Given the above, the request is not medically necessary.

MRI of Thoracic Spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation ODG Low Back (updated 01/30/15) Lumbar & Thoracic (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: The California MTUS/ACOEM Practice Guidelines state if physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test. In this case, there is no documentation of a significant functional deficit upon examination. There is no evidence of a motor or sensory deficit. There is little evidence regarding conservative treatment prior to the request for an imaging study. Given the above, the request is not medically necessary.

Sleep Study: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Pain (updated 02/23/15) Polysomnography.

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, Polysomnography.

Decision rationale: According to the Official Disability Guidelines, polysomnogram is recommended for a combination of indications. In this case, there is no documentation of any signs or symptoms related to sleep difficulty or insomnia. There is no evidence of excessive daytime somnolence, cataplexy, morning headache or intellectual deterioration. The medical necessity for the requested sleep study has not been established in this case. Therefore, the request is not medically necessary.

Solace Multi Stim Unit and Supplies - 5 Month Rental: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-116.

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

Decision rationale: The California MTUS Guidelines do not recommend transcutaneous electrotherapy as a primary treatment modality, but a 1 month home based trial may be considered as a noninvasive conservative option. In this case, there is no evidence that other appropriate pain modalities have been tried and failed including medication. There is no evidence of a successful 1 month trial prior to the request for a 5 month rental. The medical necessity for a multi stimulator unit has not been established in this case. As such, the request is not medically necessary.

Aqua Relief System Purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 369-371.

Decision rationale: The California MTUS /ACOEM Practice Guidelines state applying cold regularly for 36 to 48 hours following the acute injury and swelling is beneficial. Physical modalities have no scientifically proven efficacy in treating acute ankle or foot symptoms. There is no mention of a contraindication to at home local applications of cold packs as opposed to a motorized mechanical device. Given the above, the request is not medically necessary.

Localized Intense Neurostimulation Therapy (LINT) 1x week x6 weeks for the Thoracic Spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 97.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-300.

Decision rationale: The California MTUS/ACOEM Practice Guidelines state physical modalities such as massage, diathermy, cutaneous laser treatment, ultrasound, TENS therapy, and biofeedback have no scientifically proven efficacy in treating acute low back symptoms. The medical rationale for localized intense neurostimulation therapy for the thoracic spine has not been established in this case. As such, the request is not medically necessary at this time.

Flurbi (NAP) Cream - LA 18- grams: Upheld

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

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

Decision rationale: The California MTUS Guidelines state any compounded product that contains at least one drug that is not recommended, is not recommended as a whole. The only FDA approved topical NSAID is diclofenac. The request for a compounded cream containing flurbiprofen would not be supported. There is also no frequency listed in the request. As such, the request is not medically necessary.

Gabacloctram 180 grams: Upheld

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

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

Decision rationale: The California MTUS Guidelines state any compounded product that contains at least one drug that is not recommended, is not recommended as a whole. Gabapentin is not recommended as a topical product. Muscle relaxants are also not recommended as a topical product. There is also no frequency listed in the request. Given the above, the request is not medically necessary.

Sentra AM #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Pain (updated 02/23/15) Medical Food.

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.

Decision rationale: The Official Disability Guidelines do not recommend medical food for chronic pain. Medical food is a food which is formulated to be consumed or administered under the supervision of a physician and which is intended for the specific dietary management of a disease or condition. There is no indication of a nutritional deficit. The medical necessity for the requested medication has not been established. There is also no frequency listed in the request. Given the above, the request is not medically necessary.

Terocin Patches #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 105, 111-113.

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

Decision rationale: California MTUS Guidelines state topical analgesics 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. There is no evidence of a failure of first line oral medication prior to the initiation of a topical product. There is also no frequency listed in the request. Given the above, the request is not medically necessary.

Sentra PM #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Pain (updated 02/23/15) Sentra PM.

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, Sentra PM.

Decision rationale: The Official Disability Guidelines do not recommend Sentra PM. Sentra PM is intended for use in the management of sleep disorders associated with depression. There was no mention of a sleep disorder. The injured worker does not maintain a diagnosis of depression. The medical necessity for the requested medication has not been established. There is also no frequency listed in the request. Given the above, the request is not medically necessary.

Autonomic Nervous System Study: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Pain (updated 02/23/15) Autonomic nervous system function testing.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management.

Decision rationale: California MTUS/ACOEM Practice Guidelines state, a referral may be appropriate if the practitioner is uncomfortable with the line of inquiry outlined above, with treating a particular cause of delayed recovery, or has difficulty obtaining information or agreement to a treatment plan. In this case, autonomic nervous system is typically associated when in the presence or consideration of CRPS. There is no indication that this injured worker suffers from CRPS. There are no signs or symptoms suggestive of CRPS. The medical necessity for the requested testing has not been established. Therefore, the request is not medically necessary.

Extracorporeal Shockwave Therapy Treatment: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Elbow (updated 10/20/14).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 14 Ankle and Foot Complaints Page(s): 369-671.

Decision rationale: The California MTUS/ACOEM Practice Guidelines state there is limited evidence existing regarding extracorporeal shockwave therapy in treating plantar fasciitis to reduce pain and improve function. There was no specific quantity of sessions or duration of treatment listed in the request. The specific body part to be treated was also not listed. Given the above, the request is not medically necessary.