MAXIMUS Federal Services

Case Number:	CM15-0047856		
Date Assigned:	03/20/2015	Date of Injury:	07/07/2014
Decision Date:	05/13/2015	UR Denial Date:	02/25/2015
Priority:	Standard	Application Received:	03/13/2015

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:

This 45-year-old male sustained an industrial injury to the back on 7/7/14. Previous treatment included magnetic resonance imaging, physical therapy, acupuncture and medications. In the most recent PR-2 submitted for review, dated 1/7/15, the injured worker complained of constant lumbar spine pain with radiation down the hips and legs. Physical exam was remarkable for tenderness to palpation and spasm to the bilateral paraspinal muscles with bilateral positive Kemp's test, positive straight leg raise and positive Yeoman's test. Current diagnoses included lumbar disc displacement without myelopathy and sciatica. The treatment plan included 6 acupuncture visits and medications (Lidocaine 6%/ Gabapentin 10%/ Ketoprofen 10% 180mg, Flurbiprofen 15%/ Cyclobenzaprine 2%/ Baclofen 2%/ Lidocaine 5% 180gm and Naprosyn).

IMR ISSUES, DECISIONS AND RATIONALES

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

Lidocaine 6%/Gabapentin 10%/Ketoprofen 10% 180mg: 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 rationale: Per the MTUS, topical analgesics are recommended as an option, they 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. Many agents are compounded as monotherapy or in combination for pain control, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. Gabapentin and ketoprofen are not recommended for topical use and therefore based on the guidelines the request for Lidocaine 6%/ Gabapentin 10%/ Ketoprofen 10% 180mg is not medically necessary.

Flurbiprofen 15%/Cyclobenzaprine 2%/Baclofen 2%/Lidocaine 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 rationale: Per the MTUS, topical analgesics are recommended as an option, they 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. Many agents are compounded as monotherapy or in combination for pain control, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. Cyclobenzaprine and Baclofen are not recommended for topical use, therefore based on the guidelines the request for Flurbiprofen 15%/ Cyclobenzaprine 2%/ Baclofen 2%/ Lidocaine 5% 180gm is not medically necessary.

Naprosyn BID: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAID's Page(s): 67-68.

Decision rationale: Per the MTUS, NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence to recommend one drug in this class over another based on efficacy. In particular, there appears to be no difference between traditional NSAIDs and COX-2 NSAIDs in terms of pain relief. The main concern of selection is based on adverse effects. COX-2 NSAIDs have fewer GI side effects at the risk of increased cardiovascular side effects, although the FDA has concluded that long-term clinical trials are best interpreted to suggest that cardiovascular risk occurs with all NSAIDs and is a class effect (with naproxyn being the safest drug). There is no evidence of long-term effectiveness for pain or function. Unfortunately the quantity is not specified in the request and without this information medical necessity cannot be established. Therefore, the request is not medically necessary.

Functional Capacity Evaluation (FCE): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 137-138.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 1 Prevention Page(s): 4-5, Chronic Pain Treatment Guidelines Functional improvement measures Page(s): 48. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness for Duty / Functional capacity evaluation (FCE).

Decision rationale: The MTUS states that to determine fitness for duty, it is often necessary to "medically" gauge the capacity of the individual compared with the objective physical requirements of the job based on the safety and performance needs of the employer and expressed as essential functions. Per the ODG, Guidelines for performing an FCE: Recommended prior to admission to a Work Hardening (WH) Program, with preference for assessments tailored to a specific task or job. If a worker is actively participating in determining the suitability of a particular job, the FCE is more likely to be successful. A FCE is not as effective when the referral is less collaborative and more directive. It is important to provide as much detail as possible about the potential job to the assessor. Job specific FCEs are more helpful than general assessments. The report should be accessible to all the return to work participants. Consider an FCE if; 1) Case management is hampered by complex issues such as: Prior unsuccessful RTW attempts. Conflicting medical reporting on precautions and/or fitness for modified job. Injuries that require detailed exploration of a worker's abilities. 2) Timing is appropriate: Close or at MMI/all key medical reports secured. Additional/secondary conditions clarified. Do not proceed with an FCE if the sole purpose is to determine a worker's effort or compliance. The worker has returned to work and an ergonomic assessment has not been arranged. Functional improvement measures are recommended per the MTUS, "The importance of an assessment is to have a measure that can be used repeatedly over the course of treatment to demonstrate improvement of function, or maintenance of function that would otherwise deteriorate." However functional improvement measures are typically part of an office visit and are used differently from functional capacity evaluations. A review of the injured workers medical records that are available to me do not describe a purpose or goal for the evaluation (other than as a functional improvement measure) and without this it is difficult to establish medical necessity based on the guidelines. Therefore the request for functional capacity evaluation is not medically necessary at this time.

Range of motion measurement: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 200.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper back (Acute and Chronic)/Low-back Lumbar and Thoracic (Acute and Chronic). Range of motion/Flexibility.

Decision rationale: The MTUS/ACOEM did not specifically address the use of special range of motion measurements and therefore other guidelines were consulted. Per the ODG an inclinometer is the preferred device for obtaining accurate, reproducible measurements in a simple, practical and inexpensive way. They do not recommend computerized measures of range of motion which can be done with inclinometers, and where the result (range of motion) is of unclear therapeutic value. A review of the injured workers medical records do not reveal any specific reasoning that would necessitate an office visit for range of motion measurement and there is no discussion as to how these measurements would aid in further management of the injured worker. Therefore the request for follow up with range of motion measurement is not medically necessary.