

<b>Case Number:</b>	CM15-0078027		
<b>Date Assigned:</b>	04/29/2015	<b>Date of Injury:</b>	07/24/2014
<b>Decision Date:</b>	06/01/2015	<b>UR Denial Date:</b>	04/06/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/23/2015

### 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: Texas, California  
 Certification(s)/Specialty: Family Practice

### 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 is a 57-year-old female patient, who sustained an industrial injury on 07/24/2014. The diagnoses include cervical myospasms, rule out cervical disc protrusion, and rule out thoracic disc protrusion, thoracic myospasms, lumbar radiculitis, plantar fasciitis, anxiety, and depression. She sustained the injury while placing boxes of 200 eggs in piles. Per the progress note dated 03/24/2015, she had complaints of neck, upper/mid back, low back, and left foot pain; depression and anxiety. The physical examination revealed cervical spine- tenderness and mild decreased range of motion; thoracic spine- tenderness and pain with range of motion; lumbar spine- decreased range of motion, negative straight leg raising test; left foot- full range of motion. The medications list includes terocin patches, deprizine, dicopanol, fanatrex, synapryn, tabradol, cyclobenzaprine, gabapentin and topical capsaicin, flurbiprofen and menthol. She has had thoracic spine MRI, left foot MRI and lumbar spine MRI. She has had shockwave therapy for this injury.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Capsaicin patch, unspecified quantity: 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:** The cited Guidelines regarding topical analgesics state, "Largely experimental in use with few randomized controlled trials to determine efficacy or safety, 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 including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants." (Argoff, 2006) There is little to no research to support the use of many of these agents. "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." "Capsaicin: Recommended only as an option in patients who have not responded or are intolerant to other treatments." The cited guidelines recommend topical analgesics for neuropathic pain only when trials of antidepressants and anticonvulsants have failed to relieve symptoms. Failure of antidepressants and anticonvulsants for this injury is not specified in the records provided. Intolerance to oral medication is not specified in the records provided. The medical necessity of Capsaicin patch, unspecified quantity is not fully established for this patient. Therefore, this request is not medically necessary.

**Acupuncture therapy 1 time a week for 4 weeks for the thoracic spine, lumbar spine and left foot:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** Request: Acupuncture therapy 1 time a week for 4 weeks for the thoracic spine, lumbar spine and left foot MTUS guidelines Acupuncture Medical Treatment Guidelines 9792.24.1. Acupuncture Medical Treatment Guidelines. CA MTUS Acupuncture medical treatment guidelines cited below state that "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." The medical records provided do not specify any intolerance to pain medications that patient is taking currently. Response to previous conservative therapy including physical therapy visits is not specified in the records provided. The medical necessity of Acupuncture therapy 1 time a week for 4 weeks for the thoracic spine, lumbar spine and left foot is not fully established in this patient at this time. Therefore, this request is not medically necessary.

**Sleep study consultation:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG-TWC) Pain Procedure Summary Online Version.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter: Pain (updated 04/30/15) Polysomnography.

**Decision rationale:** Request: Sleep study consultation CA MTUS/ACOEM does not address this request, therefore ODG guidelines used. Per ODG cited below Polysomnography/sleep study is, "Recommended after at least six months of an insomnia complaint (at least four nights a week), unresponsive to behavior intervention and sedative/sleep-promoting medications, and after psychiatric etiology has been excluded." The records provided do not specify if any of the above criteria are present. A detailed clinical history regarding insomnia is not specified in the records provided. Exclusion of psychiatric etiology contributing to insomnia is not specified in the records provided. Response to sedative/sleep promoting medications and behavior intervention are not specified in the records provided. The medical necessity of sleep study consultation is not fully established for this patient. Therefore, this request is not medically necessary.