

<b>Case Number:</b>	CM15-0092856		
<b>Date Assigned:</b>	05/20/2015	<b>Date of Injury:</b>	10/16/2014
<b>Decision Date:</b>	09/22/2015	<b>UR Denial Date:</b>	04/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/14/2015

### 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: California, Arizona

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 59-year-old female, who sustained an industrial injury on 10/16/14. She reported injury to her left leg and knee. The injured worker was diagnosed as having rule out left knee meniscus tear and left knee sprain. Treatment to date has included Ibuprofen, Tramadol, a hinged knee brace and left knee x-rays. As of the PR2 dated 3/31/15, the injured worker reports 8/10 pain in the left leg and knee. She is also having 5/10 pain in her right shoulder. Objective findings include left knee flexion 100/140 degrees and extension 0/0 degrees, tenderness to palpation of the posterior knee and a positive McMurray's. The treating physician requested Capsaicin 0.025%, Flurbiprofen 15%, Gabapentin 10%, Menthol 2%, Camphor 2% - 180gm, Gabapentin 15%, Amitriptyline 4%, Dextromethorphan 10% - 180gm, Cold/Heat Therapy Unit, 2 times a day for 15-20 minutes, Rental, a knee brace, TENS/EMS Unit, 2 times a day for 15-20 min, Rental, RTW/Functional Capacity Evaluation, a urinalysis, Voltage-Actuated Sensory Nerve Conduction Threshold (VsNCT) Testing, a left knee x-ray, acupuncture (6-visits), chiropractic treatments (6-visits) and physiotherapy (6-visits).

### 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.

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

**Decision rationale:** According to the Chronic Pain Medical Treatment Guidelines, the use of topical analgesics in the treatment of chronic pain is largely experimental, and when used, is primarily recommended for the treatment of neuropathic pain when trials of first line treatments such as anti-convulsants and/or anti-depressants have failed. The guidelines go on to state that when any compounded product contains 1 medication that is not recommended, the compounded product as a whole is not recommended. Within the submitted documentation, there is lack of rationale as to why topical formulations are needed over standard oral medications for pain. Therefore, the request 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.

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

**Decision rationale:** According to the Chronic Pain Medical Treatment Guidelines, the use of topical analgesics in the treatment of chronic pain is largely experimental, and when used, is primarily recommended for the treatment of neuropathic pain when trials of first line treatments such as anti-convulsants and/or anti-depressants have failed. The guidelines go on to state that when any compounded product contains 1 medication that is not recommended, the compounded product as a whole is not recommended. Within the submitted documentation, there is lack of rationale as to why topical formulations are needed over standard oral medications for pain. Therefore, the request is not medically necessary.

**Cold/Heat Therapy Unit, 2 times a day for 15-20 minutes, Rental: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Knee & Leg Chapter, Continuous-flow cryotherapy.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Cryotherapy topic.

**Decision rationale:** According to the Official Disability Guidelines, continuous flow cryotherapy is recommended as an option after surgery for rental, up to 7 days. Purchase is not recommended. There is no mention of surgery being indicated. The request does not fall within guideline parameters; therefore, the request is not medically necessary.

**Knee Brace: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee chapter, knee brace.

**Decision rationale:** The Official Disability Guidelines states that pre-fabricated knee braces may be appropriate for patients with reconstructed knee ligaments, but custom knee braces are appropriate only when there are conditions such as abnormal limb contour, skin changes, severe osteoarthritis, the need for maximal off-loading of painful or repaired knee compartment, or severe instability on examination. Within the submitted documentation there was evidence of painful range of motion, positive McMurray's but there is no mention of the type of knee brace being requested, custom versus non-custom and the reasons behind failure to the previously used hinged knee brace mentioned. Therefore, the request is not medically necessary.

**TENS/EMS Unit, 2 times a day for 15-20 min, Rental: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS unit Page(s): 113-116.

**Decision rationale:** The CA MTUS and the ODG guidelines recommend that TENS units can be utilized for the relief of musculoskeletal pain. It is recommended that there should be an initial 1 month trial of the use of a TENS unit. The modality of the utilization of the use of the TENS unit should be documented. The guidelines recommend that the TENS units can then be purchased or authorized for long-term use if there is documentation of pain relief, improved function with range of motion, and reduction in medication utilization. There is no mention of the length of time the TENS unit is needing to be rented. A 1-month trial would be recommended for the injured workers knee pain. Therefore, the request is not medically necessary.

**RTW/Functional Capacity Evaluation: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, 2nd Edition, Independent Medical Examinations and Consultations Chapter, pgs 137-138 and Official Disability Guidelines, Fitness for Duty Chapter, Functional capacity evaluation.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92.

**Decision rationale:** The California MTUS/ACOEM Practice Guidelines state a number of functional assessment tools are available, including functional capacity evaluations (FCE) when re-assessing function and functional recovery. The ODG do not recommend proceeding with an FCE if the sole purpose is to determine a worker's effort or compliance and/or if the worker has returned to work without having an ergonomic assessment arranged. There should be mention of a previous failure to return to work, or documentation of conflicting medical reporting on precautions and/or fitness for modified duty work. There is lack of supportive documentation to warrant certification of an FCE at this time. Therefore, the request is not medically necessary.

**Urine Analysis Testing:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, screening for risk of addiction (tests). Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter, Urine drug testing (UDT).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines UDS Page(s): 77-79.

**Decision rationale:** According to the California MTUS Drug Screening section, urine drug screening can be considered to monitor for abuse in those who are taking high risk, addictive narcotic pain medications. There is lack of mention of the injured worker being high risk for abuse or aberrant behavior of controlled substances. At this time, the request is not medically necessary.

**Voltage-Actuated Sensory Nerve Conduction Threshold (VsNCT) Testing:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck Chapter, Current perception threshold (CPT) testing and [http://www.aetna.com/cpb/medical/data/300\\_399/0357.html](http://www.aetna.com/cpb/medical/data/300_399/0357.html) - Clinical Policy Bulletin: Quantitative Sensory Testing Methods, Number: 0357.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Chronic Pain Section, VsNCT.

**Decision rationale:** Voltage-actuated sensory nerve conduction threshold (VSNCT) is not medically necessary per the ODG Guidelines. The CA MTUS Chronic Pain and CA MTUS ACOEM do not address the request for voltage actuated sensory nerve conduction testing. The guidelines state that this is different and distinct from assessment of nerve conduction velocity, amplitude, and latency. It is also different from short-latency somatosensory evoked potentials. CMS concludes that the use of any type of VSNCT device, to diagnose sensory neuropathies or radiculopathies is not reasonable or necessary. Per ODG guidelines, there are no clinical studies demonstrating that quantitative tests of sensation improve the management and clinical outcomes of a patient over standard qualitative methods of sensory testing. The submitted documentation

reviewed lacks a clear rationale behind why VsNCT is necessary over standard testing. Therefore, the request is not medically necessary.

**X-Rays, Left Knee:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 341-343.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 329-352.

**Decision rationale:** The MTUS Guidelines support the use of knee x-rays when there is knee trauma and examination shows fluid in the knee joint 24 hours after direct knee trauma, tenderness over the fibular head or kneecap, an inability to take even a few steps within a week of the trauma, or an inability to bend the knee at least ninety degrees. Most knee problems recover quickly once red flag issues are ruled out. Within the submitted documentation, there is lack of supportive information to warrant an X-ray. Range of motion is beyond 90 degrees. There is no instability or tenderness over regions mentioned above, to warrant non-adherence to guideline recommendations. Therefore, the request is not medically necessary

**Acupuncture, 6-visits (once a week for 6 weeks):** Upheld

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

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

**Decision rationale:** According to the MTUS guidelines, acupuncture can be considered when pain medications are not tolerated, or reduced. It may also be used as an adjunct to physical rehabilitation or surgical intervention to hasten functional recovery. Typical time frame needed to produce functional benefit is 3-6 sessions. There is no mention of acupuncture being used as an adjunct to therapeutic exercise, nor is there mention of which body part is needing treatment. At this time, the request is not medically necessary.

**Chiropractic, 6-visits (once a week for 6 weeks):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy and manipulation Page(s): 58-60.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Manipulative Therapy Page(s): 58-59.

**Decision rationale:** California MTUS Guidelines recommend up to 18 visits of chiropractic therapy with evidence of objective functional improvement. The request does not mention what body part is needing treatment and without this information, the request is not medically necessary.

**Physiotherapy, 6-sessions (once a week for 6 weeks): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**Decision rationale:** The California MTUS recommends 8-10 sessions of physical therapy for various myalgias or neuralgias. The request as submitted does not mention the area that needs treatment and without this information, the request is not medically necessary.