MAXIMUS Federal Services

Case Number:	CM13-0022633		
Date Assigned:	11/13/2013	Date of Injury:	12/22/2009
Decision Date:	01/24/2014	UR Denial Date:	08/27/2013
Priority:	Standard	Application Received:	09/10/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation and is licensed to practice in California. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 55-year-old male who reported injury on 12/22/2009. The mechanism of injury was not provided. The patient had low back pain and hip pain. The patient's diagnoses were noted to include left hip pain OA, left hip pain and lumbar spine bulges with impingement and radiculopathy and cervical spine disc bulge with radiculopathy. The request was made for chiropractic therapy 2 times a week for 6 weeks, acupuncture sessions 2 times a week for 6 weeks, EMG of the upper and lower extremities, NCV of the upper and lower extremities, extracorporeal shock wave therapy (ESWT), neurostimulator TENS/EMS unit, pain management, and 30 times Medrox patch refills.

IMR ISSUES, DECISIONS AND RATIONALES

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

chiropractic therapy 2 times a week for 6 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation ODG

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

Decision rationale: CA MTUS states that manual therapy and manipulation is recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the

treatment of musculoskeletal pain. For the low back, therapy is recommended initially in a therapeutic trial of 6 sessions and with objective functional improvement, a total of up to 18 visits over 6-8 weeks may be appropriate. Treatment for flare-ups requires a need for re-evaluation of prior treatment success. Treatment is not recommended for the ankle & foot, carpal tunnel syndrome, the forearm, wrist, & hand or the knee. Also, the time to produce effect is indicated as 4 to 6 treatments several studies of manipulation have looked at duration of treatment, and they generally showed measured improvement within the first few weeks or 3-6 visits of chiropractic treatment, although improvement tapered off after the initial sessions. If chiropractic treatment is going to be effective, there should be some outward sign of subjective or objective improvement within the first 6 visits. The clinical documentation submitted for review failed to provide the body part that therapy was being requested. Additionally, it failed to provide previous treatments and the patient's functional response to those treatments. Given the above, the request for chiropractic therapy 2 times a week for 6 weeks is not medically necessary.

acupuncture sessions 2 times 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: The Physician Reviewer's decision rationale: California MTUS guidelines recommend Acupuncture as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. The time to produce functional improvement is 3 - 6 treatments and Acupuncture treatments may be extended if functional improvement is documented including either a clinically significant improvement in activities of daily living or a reduction in work restrictions. The clinical documentation submitted for review failed to provide the body part that therapy was being requested. It failed to provide previous treatments and the patient's functional response to prior treatments. Given the above, the request for acupuncture sessions 2 times a week for 6 weeks is not medically necessary.

Electromyography (EMG) of upper and lower extremities: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 177-179; 303-305.

Decision rationale: ACOEM indicates that Electromyography (EMG), including H reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms and/or or neck and upper back symptoms lasting more than three or four weeks. The clinical documentation submitted for review indicated that the patient had bilateral lower extremities strength of 4/5. The patient was noted to ambulate with a cane and have an antalgic gait. The straight leg raise was positive bilaterally with decreased sensation on the left.

However, there was a lack of documentation of a prior examination to indicate the patient had prior testing or did not have prior testing. While it was noted the patient had decreased sensation and decreased strength, there was a lack of a thorough examination including myotomal and dermatomal findings to support the necessity for the testing. Given the above, the request for EMG of the upper and lower extremities is not medically necessary.

Nerve Conduction Velocities (NCV) of upper and lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179,Chronic Pain Treatment Guidelines.

Decision rationale: ACOEM states that Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks for the upper back. However, ACOEM and CA MTUS do not address NCV for the lower extremities. Official Disability Guidelines states that there minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. The clinical documentation submitted for review indicated that the patient had bilateral lower extremities strength of 4/5. The patient was noted to ambulate with a cane and have an antalgic gait. The straight leg raise was positive bilaterally with decreased sensation on the left. However, there was a lack of documentation of a prior examination to indicate the patient had prior testing or did not have prior testing. There was a lack of documentation of justification for both the EMG and the NCV to be performed along with a lack of a thorough objective examination. Given the above, the request for NCV of the upper and lower extremities is not medically necessary.

extracorporeal shockwave therapy (ESWT): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation peer reviewed literature "Extracorporeal Shock Wave Therapy for Orthopedic Conditions".

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation other medical treatment guideline or medical evidence: Wang, Ching-Jen. "Extracorporeal shockwave therapy in musculoskeletal disorders." Journal of orthopaedic surgery and research 7.1 (2012): 1-8.

Decision rationale: CA MTUS, ACOEM and Official Disability Guidelines do not address extracorporeal shockwave therapy for the hip. Per Wan, Chin-Jen (2012) "The application of extracorporeal shockwave therapy (ESWT) in musculoskeletal disorders has been around for more than a decade and is primarily used in the treatment of sports related over-use tendinopathies such as proximal plantar fasciitis of the heel, lateral epicondylitis of the elbow, calcific or non-calcific tendonitis of the shoulder and patellar tendinopathy etc." The patient was noted to have 3 sessions of ESWT for his hip. The clinical documentation submitted for review

failed to provide the patient had functional benefits from the ESWT. Additionally, it failed to provide which body part the ESWT was being requested for. Given the lack of documentation, the request for extracorporeal shock wave therapy (ESWT), unknown number of sessions, is not medically necessary.

neurostimulator TEN S/EMS unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Transcutaneous Electrical Nerve Stimulation Page(s): 114-115.

Decision rationale: CA MTUS Guidelines do not recommend a TENS unit as a primary treatment modality but a 1 month home based trial may be considered as a noninvasive conservative option if used as an adjunct to a program of evidence based functional restoration for neuropathic pain. In order for a TENS unit to be trialed, there has be evidence of that other appropriate pain modalities have been tried and failed including medication, and there must be documentation of pain of at least 3 months. Clinical documentation submitted for review failed to provide the required documentation that other modalities had be trialed and failed. Additionally, it failed to provide whether the request was for purchase or rental and it failed to provide the patient would be using this as an adjunct to other therapies. Given the above, the request for neurostimulator TENS/EMS unit is not medically necessary.

pain management: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation ODG

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Chronic pain programs (functional restoration programs) Page(s): 30.

Decision rationale: CA MTUS Guidelines recommend chronic pain programs for patients with conditions that put them at risk of delayed recovery. Clinical documentation submitted for review failed to provide documentation indicating whether the patient was to be referred to a chronic pain program or a pain management physician. Given the lack of clarification, the request for pain management is not medically necessary.

prescription for 30 x Medrox patch refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Salicylate; Topical Analgesic; Capsaicin Page(s): 105; 111; 112.

Decision rationale: CA MTUS does not specifically address Medrox, however, the CA MTUS states that topical analgesics are "Largely experimental in use with few randomized control trials to determine efficacy or safety....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....There have been no studies of a 0.0375% formulation of capsaicin and there is no current indication that this increase over a 0.025% formulation would provide any further efficacy." Additionally it indicates that Topical Salicylates are approved for chronic pain. According to the Medrox package insert, Medrox is a topical analgesic containing Menthol 5.00% and 0.0375% Capsaicin and it is indicated for the "temporary relief of minor aches and muscle pains associated with arthritis, simple backache, strains, muscle soreness, and stiffness." Clinical documentation submitted for review failed to provide the number of refills being requested. Additionally, Capsaicin is not approved and Medrox is being used for chronic pain, by the foregoing guidelines, the request for Medrox is not certified as medically necessary.