

Case Number:	CM13-0024259		
Date Assigned:	12/11/2013	Date of Injury:	07/10/2006
Decision Date:	01/30/2014	UR Denial Date:	09/05/2013
Priority:	Standard	Application Received:	09/16/2013

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 and 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 58-year-old male who reported an injury on 07/10/2006. The mechanism of injury was lifting. The patient's initial course of treatment included rest, activity modification, medications, hot/cold packs, massage, electrode treatments, an unspecified injection, and physical therapy. The patient's symptoms persisted and he was subsequently referred for an MRI of the lumbar spine and an EMG/NCV, results of both are not included or discussed in the medical records. The patient has current complaints of pain in the bilateral upper extremities, left greater than right; pain in the low back radiating to both hips and legs; and frequent dull pain in the bilateral lower extremities. The patient's current medications include tramadol and gabapentin, unspecified doses and frequencies.

IMR ISSUES, DECISIONS AND RATIONALES

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

Acupuncture two (2) times a week for four (4) weeks to the low back: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The California Acupuncture Medical Treatment Guidelines recommend acupuncture as an option when pain medications are not tolerated, or as an adjunct to physical

rehabilitation. It can be used to reduce pain, reduce inflammation, reduce blood flow, increase range of motion, decrease side effects of medication induced nausea, promote relaxation, and reduce muscle spasm. The most recent clinical note dated 08/19/2013 revealed that the patient did have muscle spasms in his lumbar spine area. Guidelines recommend that 3 to 6 treatments be initiated and may be extended if functional improvement is documented. The current request for 8 acupuncture treatments exceeds guideline recommendations. As such, the decision for acupuncture 2 times a week for 4 weeks to the low back is non-certified.

Physical therapy two (2) times a week for four (4) weeks for the low back: Upheld

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

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

Decision rationale: California MTUS Guidelines recommend active therapy to increase flexibility, strength, endurance, function, range of motion, and to alleviate discomfort. For unspecified myalgia or myositis, 6 initial visits of physical therapy are recommended with the extension of up to 9 or 10 visits with objective documentation of functional improvement. The current request for 8 sessions exceeds guideline recommendations. As such, the decision for physical therapy 2 times a week for 4 weeks for the low back is non-certified.

MRI lumbar spine: Upheld

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

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, MRI

Decision rationale: The California MTUS/ ACOEM Guidelines did not specifically address repeat MRI, therefore, the Official Disability Guidelines were supplemented. ODG does not recommend repeat MRI unless there has been an emergence of red flags or a significant change in symptoms suggesting significant pathology such as tumor, infection, fracture, neural compression, or recurrent disc herniation. It was noted in the clinical note dated 08/19/2013 that the patient had a previous MRI on an unknown date; however, results were not included in the medical records for review. The only other recommendation for a repeat MRI is for spinal interventions including injections or surgery. In the clinical records submitted for review there is no evidence of documentation regarding the anticipation of any future injections or surgery. There is also no documentation detailing the progression of the patient's symptoms or any red flags that have emerged. As such, the decision for MRI, lumbar spine is non-certified.

Functional Capacity Evaluation (FCE): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 7, Independent Medical Examinations and Consultations.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Fitness for Duty, Functional Capacity Evaluation.

Decision rationale: The California MTUS/ACOEM Guidelines state an FCE is an appropriate functional assessment tool to reassess function and functional recovery. ODG recommends Functional Capacity Evaluations if the patient has had prior unsuccessful return to work attempts; conflicting medical reporting on precautions and/or fitness for modified duties; injuries that require detailed exploration of a worker's abilities; a patient that is close or at maximum medical improvement; and all additional or secondary conditions have been clarified. ODG does not recommend proceeding with an FCE if the sole purpose is to determine a worker's effort or compliance or the worker has returned to work and an ergonomic assessment has not been arranged. The recent clinical note dated 08/19/2013 is unclear in the patient's current work status. It states both that the patient is currently working for his pre-injury employer and also that he was placed on temporary total disability. There was also no mention in the clinical records of any prior return to work attempts. As such, the medical necessity for a Functional Capacity Evaluation cannot be determined and the request for 1 Functional Capacity Evaluation is non-certified.

EMG/NCV lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation ODG (Low Back Chapter).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-309.

Decision rationale: The California MTUS/ACOEM Guidelines recommend the use of EMG to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than 3 or 4 weeks. In the clinical note dated 05/21/2013, the patient is noted to have a decrease in range of motion to the lumbar spine, a positive straight leg test bilaterally, and decreased sensation to pinprick in bilateral L5 distribution. There was also noted bilateral motor strength of 5/5 and normal deep tendon reflexes. The clinical note on 08/19/2013 supports the previous findings noting decreased sensation, significant decrease in range of motion, and muscle strength of 5/5 bilaterally. However, these findings indicate an obvious radiculitis and CA MTUS/ACOEM Guidelines do not recommend EMG for clinically obvious radiculopathy. As such, the request for EMG/NCV to the lumbar spine is non-certified.

Home exercise kit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Knee Chapter, Exercise Equipment.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Exercise Page(s): 46-47.

Decision rationale: California MTUS Guidelines do recommend exercise; however, there is no sufficient evidence to support the recommendation of any particular exercise regimen over any other exercise regimen. Guidelines state that simple walking and simple strength training improved functional status, key symptoms, and self efficacy in patients. As such, there is no need for any particular equipment and the request for home exercise kit is non-certified.

Lumbar brace: 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): 308. Decision based on Non-MTUS Citation ODG.

Decision rationale: California MTUS/ACOEM Guidelines do not recommend the use of lumbar supports for the treatment of low back disorders as studies do not support that they have any lasting benefit beyond the acute phase of symptom relief. CA MTUS/ACOEM Guidelines do recommend the use of a corset for the prevention of low back pain in an occupational setting; however, it is unclear if the patient is currently working. As such, the recommendation for lumbar brace is non-certified.

Heat/cold pack: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (low back chapter).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308.

Decision rationale: The California MTUS /ACOEM recommends the use of at home applications of cold in the first few days of acute complaint; there after, applications of heat or cold is recommended for the treatment of low back disorders. However, the clinical information submitted did not detail prior attempts made by the patient to use at home self application of heat and/or cold packs. As such, the request for heat/cold pack is non-certified.

Omeprazole: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Omeprazole Page(s): 68.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68.

Decision rationale: California MTUS guidelines recommend the use of proton pump inhibitors such as Omeprazole for patients who are at high risk for gastrointestinal events. The characteristics of a high risk patient include age of over 65 years old; history of a peptic ulcer, GI bleeding, or perforation; concurrent use of aspirin, corticosteroids, and/or an anticoagulant; or high dose/multiple NSAID use. The patient exhibits none of those characteristics, has no complaints of GI irritation, and is only using a topical NSAID. As such, there is no indication for a proton pump inhibitor and the request for Omeprazole is non-certified.

Tramadol 150 ER: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 79-81.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-95.

Decision rationale: The California MTUS guidelines recommend the use of opioids in the treatment of chronic pain. In managing ongoing and long-term use of opioid medications, guidelines recommend the certain outcomes be measured. These measures include documenting the patient's current pain level; the least reported pain since last clinical visit; the average pain level; the intensity of pain after taking the opioid; how long it takes for pain relief; how long pain relief lasts; and monitoring medication compliance through the use of urine drug screens. There was no documentation provided in the medical records for review regarding the effects of the opioid medications on the patient's pain or functional abilities. There was also no submission of a recent urine drug screen. As such, the efficacy for the medication cannot be determined. Therefore, the request for tramadol 150 ER is non-certified.

Cyclobenzaprine: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-65.

Decision rationale: California MTUS guidelines recommend non-sedating muscle relaxants as a second line option for short-term treatment of acute exacerbations of chronic lower back pain. There is no evidence however, that muscle relaxants provide any benefit beyond the use of NSAIDs. Studies also report that efficacy tends to diminish over time and prolonged use may lead to dependence. Cyclobenzaprine in particular, is recommended for a short course of physical therapy. Initial dosing of Cyclobenzaprine is recommended as 5 mg 3 times a day and can be increased to 10 mg 3 times a day. This medication is not recommended to be used for longer than 2 to 3 weeks. It appears that this is a new medication for the patient as first note of it

was made in the 08/19/2013 clinical note. There is no specification of dosage or frequency in the request and therefore, guideline compliance cannot be determined. As such, the request for Cyclobenzaprine is non-certified.

Capsaicin 0.025%/Flurbiprofen 30%/Methyl 4%: 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 Topical Analgesics Page(s): 111-113.

Decision rationale: California MTUS guidelines recommend topical analgesics to treat musculoskeletal pain. Guidelines also state that for a compounded medication, any product that is not recommended in the guidelines renders the entire compounded product not recommended. Guidelines state that there is little evidence to support the use of topical NSAIDs for the treatment of osteoarthritis to the spine and it is not recommended for neuropathic pain. The only approved topical NSAID is Voltaren gel 1%. The requested topical agent partially consists of Flurbiprofen which is not recommended by guidelines. As such, the request for capsaicin 0.025%/Flurbiprofen 30%/methyl 4% is non-certified.