

Case Number:	CM13-0026615		
Date Assigned:	11/22/2013	Date of Injury:	02/16/2010
Decision Date:	01/29/2014	UR Denial Date:	08/30/2013
Priority:	Standard	Application Received:	09/19/2013

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 Illinois. 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 46-year-old female who reported injury on 02/16/2010. The mechanism of injury was noted to be the patient was moving a gate with a wheel that was broken and injured her neck. The documentation dated 07/31/2013 revealed the request was for 12 sessions of chiropractic care; MRI of the thoracic spine; TENS EMS unit; VSNCT upper extremity; capsaicin 0.025%, Flurbiprofen 30%, methyl salicylate 4%; Flurbiprofen 20%, and tramadol 20%; Medrox patches; x-rays of the thoracic spine; unknown LINT therapy sessions; and unknown ESWT. The patient's diagnosis was noted to be thoracic spine sprain/strain.

IMR ISSUES, DECISIONS AND RATIONALES

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

twelve (12) chiropractic sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation ODG Chiropractic Guidelines

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

Decision rationale: The California 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. The treatment for flare-ups requires a need for re-evaluation of prior treatment success. 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 indicated the patient had positive tenderness to palpation of the trapezius and paraspinal muscles T3-8/9. The patient was noted to have a positive myospasms. However, clinical documentation submitted for review failed to provide the necessity for 12 sessions of chiropractic care; and additionally, it failed to provide the part of the body that was supposed to receive the chiropractic sessions. Given the above and the lack of documentation, the request for 12 chiropractic sessions is not medically necessary.

MRI of the thoracic spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: The ACOEM guidelines recommend MRI if physiologic evidence indicates tissue insult or nerve impingement. However, clinical documentation submitted for review failed to provide previous studies that had been performed. Additionally, there was a lack of documentation indicating the patient had physiologic evidence of tissue insult or nerve impairment. The physical examination revealed the patient had 5/5 strength and was noted to gross sensation and motor intact. Given the above, the request or an MRI of the thoracic spine is not medically necessary.

TENS- EMS unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Section Page(s): 115-116.

Decision rationale: The California MTUS Guidelines indicate a TENS unit is not recommended as a primary treatment modality, but a 1-month home-based TENS trial may be considered as a noninvasive conservative option is used as an adjunct to a program of evidence-based functional restoration for neuropathic pain if there is documentation of pain of at least 3 months in duration and there is evidence that other appropriate pain modalities have been tried (including medications) and failed. The clinical documentation submitted for review indicated that the patient had previously used a TENS unit and it had helped. It to objectively indicate was the

word "helped" meant with use of the standard VAS scale and functional benefit. It failed to provide documentation that the above criteria had been met. Additionally, it failed to provide whether the TENS unit was for purchase or for rental. Given the above and the lack of documentation, the request for a TENS/EMS unit is not medically necessary.

VSNCT upper extremity: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck & Upper Back Chapter, VSNCT, Online Version

Decision rationale: The California MTUS/ACOEM does not address VSNCT. Per Official Disability Guidelines current perception threshold (CPT) testing is not recommended. There are no clinical studies demonstrating that quantitative tests of sensation improve the management and clinical outcomes of patients over standard qualitative methods of sensory testing. Clinical documentation submitted for review failed to provide documentation of exceptional factors to warrant nonadherence to guideline recommendations. Additionally, the patient's motor strength and gross sensation was noted to be intact. Given the above, the request for VSNCT for the upper extremity is not medically necessary.

Capsaicin 0.025% Flurbiprofen 30% Methyl Salicylate 4%: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Flurbiprofen Section, Topical Analgesics Section, Capsaicin Section, Topical Salicylates Page(s).

Decision rationale: Flurbiprofen is classified as a non-steroidal anti-inflammatory agent. The CA MTUS indicates topical analgesics are "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....Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period." This agent is not currently FDA approved for a topical application. FDA approved routes of administration for Flurbiprofen include oral tablets and ophthalmologic solution. A search of the National Library of Medicine - National Institute of Health (NLM-NIH) database demonstrated no high quality human studies evaluating the safety and efficacy of this medication through dermal patches or topical administration... Capsaicin: Recommended only as an option in patients who have not responded or are intolerant to other treatments.... California MTUS guidelines recommend Topical Salicylates. Methyl Salicylate 4% is one of the ingredients of

this compound." As the topical Flurbiprofen is not supported by the FDA or the treatment guidelines, the request is not certified as medically necessary.

Flurbiprofen 20% Tramadol 20%: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Flurbiprofen Section, Topical Analgesics Section, Tramadol Section Page(s): 72, 111, 82.

Decision rationale: Flurbiprofen is classified as a non-steroidal anti-inflammatory agent. The California MTUS indicates topical analgesics are "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....Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period." This agent is not currently FDA approved for a topical application. FDA approved routes of administration for Flurbiprofen include oral tablets and ophthalmologic solution...Tramadol is not recommended as a first line therapy ..." The topical Flurbiprofen is not supported by the FDA or the treatment guidelines and there was a lack of documentation indicating the efficacy of the medication. Clinical documentation submitted for review failed to provide the necessity for 2 prescriptions of Flurbiprofen. Given the above, the request for Flurbiprofen 20% and tramadol 20% is not medically necessary.

Medrox patches: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Salicylate Section, Topical Analgesic Section, Capsaicin Section, Medrox Online Drug Ins.

Decision rationale: The California MTUS does not specifically address Medrox, however, the California 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." 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.

x-ray of the thoracic spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 182.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: The ACOEM Guidelines indicate that lumbar spine x-rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least 6 weeks. The patient was noted to have back pain and soreness. They were noted to have strength of 5/5 and gross sensation and motor was noted to be intact. Clinical documentation submitted for review failed to provide the necessity and failed to provide documentation of exceptional factors to warrant nonadherence to guideline recommendations. Given the above, the request for x-ray of the thoracic spine is not medically necessary.

unknown LINT therapy sessions: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NMES Section Page(s): 120.

Decision rationale: The California MTUS guidelines indicate that a neuromuscular electrical stimulation (NMES devices) is not recommended. NMES is used primarily as part of a rehabilitation program following stroke and there is no evidence to support its use in chronic pain. There are no intervention trials suggesting benefit from NMES for chronic pain. The clinical documentation submitted for review failed to provide the necessity for the requested treatment. Additionally, it failed to provide documentation of exceptional factors to warrant nonadherence to guideline recommendations. It failed to provide the frequency and duration of the LINT therapy sessions. Given the above, the request for unknown number of LINT therapy sessions is not medically necessary.

unknown ESWT: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: The California MTUS, ACOEM, and Official Disability Guidelines are silent regarding the use of ESWT in low back therapy. Per Wang, Ching-Jen (2012) "the application of extracorporeal shockwave therapy (ESWT) in musculoskeletal disorders had been around for more than a decade and is primarily utilized in treatment of sports-related overuse tendinopathy 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." Clinical documentation submitted for review failed to provide a necessity for the therapy. Additionally, it failed to provide what body part the therapy was being requested for. Given the above and the lack of documentation, the request for unknown ESWT is not medically necessary.