MAXIMUS Federal Services

Case Number:	CM13-0034638		
Date Assigned:	12/11/2013	Date of Injury:	07/10/2013
Decision Date:	01/29/2014	UR Denial Date:	09/24/2013
Priority:	Standard	Application Received:	10/15/2013

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 Pain Medicine, and is licensed to practice in Ohio and Texas. 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 64-year-old female who reported an injury on 07/10/2013. The patient is currently diagnosed with spinal stenosis and left index trigger finger. The patient was recently seen by [redacted] on 09/05/2013. The patient reported slight intermittent and occasionally severe low back pain and difficulty sleeping. The patient also reported left index trigger finger pain. Physical examination revealed positive squat and negative heel and toe walk, tenderness to palpation over the lumbar spine, positive straight leg raising at 60 degrees bilaterally, normal range of motion, a well healed surgical scar over bilateral wrists consistent with prior carpal tunnel release, 2+ tenderness to palpation over the left index finger, normal range of motion of bilateral wrists and digits, and 5/5 strength in all muscle groups. Treatment recommendations included topical compounded creams, interferential unit, and cold therapy unit, a request for acupuncture therapy, a request for an MRI and a urinalysis, and a request for a referral to pain management and orthopedic specialists.

IMR ISSUES, DECISIONS AND RATIONALES

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

One intespec IF II: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117-120.

Decision rationale: The Physician Reviewer's decision rationale: The California MTUS Guidelines state interferential stimulation is not recommended as an isolated intervention and patient selection criteria should be used. There should be documentation that pain is ineffectively controlled due to diminished effectiveness of medication or side effects of medication, history of substance abuse, significant pain from postoperative conditions, or unresponsiveness to conservative measures. The California MTUS Guidelines also recommend a 1-month trial of an interferential unit. As per the clinical notes submitted, the patient does not appear to meet criteria as outlined above for an interferential unit. In addition, the medical rationale for the requested treatment modality has not been provided. Therefore, the current request cannot be determined as medically appropriate. As such, the request for 1 intespec IF II is non-certified.

Unknown monthly supplies: 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 Page(s): 117-120.

Decision rationale: The Physician Reviewer's decision rationale: The monthly supplies for this unit are not medically necessary, as the interferential unit itself has not been approved. The request for Unknown monthly supplies is non-certified.

One cold therapy unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-Neck and Upper Back (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Cold/heat packs.

Decision rationale: The Physician Reviewer's decision rationale: The California MTUS/ACOEM Practice Guidelines state physical modalities have no proven efficacy in treating acute low back symptoms. At home local applications of heat or cold are as effective as those performed by therapists. The Official Disability Guidelines state cold and heat packs are recommended as an option for acute pain. Continuous flow cryotherapy units are indicated for knee and shoulder surgeries. The medical necessity for the requested service has not been established. As such, the request for 1 cold therapy unit is non certified.

Unknown hot/cold pads: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Cold/heat packs

Decision rationale: The Physician Reviewer's decision rationale: The California MTUS/ACOEM Practice Guidelines state physical modalities have no proven efficacy in treating acute low back symptoms. At home local applications of heat or cold are as effective as those performed by therapists. The Official Disability Guidelines state cold and heat packs are recommended as an option for acute pain. The medical necessity for the requested service has not been established. As such, the request for Unknown hot/cold pads is non-certified.

Unknown assy straps 16"/14":: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-300.

Decision rationale: Assy straps are to be used with the cold therapy unit. Based on the concurrent non-certification for the cold therapy unit, the current request for assy straps is not medically necessary. As such, the request for Unknown assy straps 16"/14" is non-certified.

One pain management consult: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 289,296,305.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Office Visits.

Decision rationale: : The California MTUS/ACOEM Practice Guidelines state referral may be appropriate if the practitioner is uncomfortable with the line of inquiry, with treating a particular cause of delayed recovery, or has difficulty obtaining information or agreement to a treatment plan. As per the clinical notes submitted, the patient has been diagnosed with spinal stenosis, and has received epidural steroid injections with benefit. There is no evidence of persistent pain with possible underlying tissue pathology. Based on the clinical information received, the request for 1 pain management consult is non-certified.

One ortho referral: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Office Visits

Decision rationale: The Physician Reviewer's decision rationale: The California MTUS/ACOEM Practice Guidelines state referral may be appropriate if the practitioner is uncomfortable with the line of inquiry, with treating a particular cause of delayed recovery, or has difficulty obtaining information or agreement to a treatment plan. As per the clinical notes submitted, the patient has been diagnosed with spinal stenosis, and has received epidural steroid injections with benefit. There is no evidence of persistent pain with possible underlying tissue pathology. Additionally, the physical examination failed to provide evidence of radiculopathy or significant objective findings to consider an orthopedic consultation at this time. Based on the clinical information received, the request for 1 ortho referral is non-certified.

One U/A test: 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 Page(s): 43,77,89. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Urine Drug Testing

Decision rationale: The Physician Reviewer's decision rationale: The California MTUS Guidelines state drug testing is recommended as an option, using a urine drug screen to assess for the use or presence of illegal drugs. The Official Disability Guidelines state the frequency of urine drug testing should be based on documented evidence of risk stratification including the use of a testing instrument. Patients at low risk of addiction or aberrant behavior should be tested within 6 months of initiation of therapy and on a yearly basis thereafter. As per the clinical notes submitted, there is no documentation of non-compliance or misuse of medication. There is also no evidence that this patient falls under a high-risk category that would require frequent monitoring. A review of the reports indicates that the patient has not been prescribed opioids in the past or being considered for opioids in the future. Therefore, the medical necessity has not been established. As such, the request for 1 U/A test is non-certified.

Eight chiropractic sessions: Upheld

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

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

Decision rationale: The Physician Reviewer's decision rationale: The California MTUS Guidelines state manual therapy and manipulation is recommended for chronic pain if caused by a musculoskeletal condition. Treatment for the low back is recommended as an option with a therapeutic trial of 6 visits over 2 weeks. As per the clinical notes submitted, the patient has not been treated with acupuncture treatment for her condition in the past. However, the current request for 8 chiropractic sessions exceeds Guideline recommendations for a trial of 6 visits over 2 weeks followed by evidence of objective functional improvement. Therefore, the current request cannot be determined as medically appropriate. As such, the request for 8 chiropractic sessions is non-certified.

One prescription for topical compound cream: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

Decision rationale: The Physician Reviewer's decision rationale: The California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. As per the clinical notes submitted, there is no indication that this patient has failed to respond to first line oral medication prior to the initiation of a topical analgesic. Therefore, the patient does not currently meet criteria for the use of a topical analgesic. As such, the request for 1 prescription for topical compound cream is non-certified.