

<b>Case Number:</b>	CM13-0035789		
<b>Date Assigned:</b>	03/03/2014	<b>Date of Injury:</b>	02/28/2007
<b>Decision Date:</b>	05/08/2014	<b>UR Denial Date:</b>	09/27/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/17/2013

### 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. The expert reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Florida. 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/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 68-year-old female who reported an injury on 02/28/2007. The mechanism of injury was not provided in the medical records. Her course of treatment to date is unclear; however, she has been diagnosed with bilateral knee degenerative joint disease, left hand sprain/strain, and lumbar disc bulge with radiculopathy. The only clinical note submitted for review is dated 06/08/2013, and is mostly illegible. However, it was noted that the patient's lumbar spine was tender to palpation from L3-S1, and that the patient has left knee pain was greater than the right knee.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **CHIROPRACTIC SESSIONS 1 TIMER PER WEEK FOR 6 WEEKS: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 59.

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

**Decision rationale:** The California MTUS/ACOEM Guidelines recommend manual therapy to treat pain associated with musculoskeletal conditions. Guidelines recommend an initial trial of 6 visits, for treatment of the lumbar spine, to help increase functional ability and assist

participation in a therapeutic exercise program. The only clinical note submitted for review dated 06/08/2013 did not provide any evidence that the patient had any functional limitations in the lumbar spine, and only noted that there was tenderness on palpation. The patient's subjective complaints did not include those of the lumbar spine. In regard to the knee, California Guidelines do not recommend manipulation for this body region. Additionally, the current request does not specify which body region is to be treated; and therefore, medical necessity cannot be determined. As such, the request for chiropractic sessions 1 time per week for 6 weeks is non-certified.

**ACUPUNCTURE SESSIONS 1 TIME PER 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 California MTUS acupuncture treatment guidelines recommend an initial trial, between 3 and 6 treatments, of acupuncture for patients complaining of pain, anxiety, decreased range of motion, and nausea. Although the current request for 6 visits is appropriate, the request does not indicate which body part is to be treated. As the clinical note dated 06/08/2013 was mostly illegible, it is unclear why the acupuncture is being requested. As such, medical necessity cannot be determined, and the request for acupuncture sessions 1 time per week for 6 weeks is non-certified.

**EXTRACORPOREAL SHOCK WAVE THERAPY: 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), Low Back, Knee & Leg, Extracorporeal Shockwave Therapy (ESWT)

**Decision rationale:** The California MTUS/ACOEM Guidelines do not specifically address extracorporeal shockwave therapy; therefore, the Official Disability Guidelines were supplemented. ODG states that extracorporeal shockwave therapy is under study in treating the knee, and further studies should be performed prior to implementing this therapy. In addition, ODG does not recommend shockwave therapy in treating the lumbar spine. As the request did not specify which body part was to be treated with this therapy, and Official Disability Guidelines do not recommend this therapy at this time, the medical necessity for this request has not been established. Additionally, the request does not identify the desired amount of therapy sessions. As such, the request for extracorporeal shockwave therapy is non-certified.

**TRIGGER POINT'S IMPEDANCE IMAGING, LOCALIZED INTENSE NEUROSTIMULATION THERAPY(TPI/LINT): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Percutaneous Neuromodulation Therapy (PNT) Page(s): 98.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Gorenberg, M., & Schwartz, K. (2013). Imaging-guided hyperstimulation analgesia in low back pain. *Journal of pain research*, 6, 487. Schabrun, S. M., Cannan, A., Mullens, R., Dunphy, M., Pearson, T., Lau, C., & Chipchase, L. S. (2012). The Effect of Interactive Neu

**Decision rationale:** The California MTUS/ACOEM Guidelines and Official Disability Guidelines do not address trigger point impedance imaging or localized intense neurostimulation therapy (TPI-LINT); therefore, current medical literature was supplemented. Although the current medical literature indicates that this type of therapy may be beneficial, each article indicated that further studies were needed before it can be implemented as an acceptable treatment. As this treatment is still under study, and there was no request regarding the amount of sessions needed or what body region would be treated, this treatment is not indicated at this time. As such, the request for trigger point impedance imaging, localized intense neurostimulation therapy (TPI-LINT) is non-certified.

**VOLTAGE-ACTUATED SENSORY NERVE CONDUCTION THRESHOLD(VSNCT):**  
Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pain Research and Treatment, volume 2011 (2011), Article ID: 152307, 6 pages, <http://dx.doi.org/10.1155/2011/152307>.

**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:** The California MTUS/ACOEM Guidelines recommend nerve conduction studies for patients experiencing subtle, focal, neurologic defects. As the clinical notes submitted for review did not provide a thorough physical examination, there is no evidence that the patient is experiencing neurologic symptoms. In addition, the request does not specify whether this nerve conduction study is to be performed to the upper or lower extremities; and therefore, medical necessity and guideline compliance cannot be determined. As such, the request for voltage-actuated sensory nerve conduction threshold (VSNCT) is non-certified.

**INITIAL PROLOTHERAPY CONSULT LUMBAR:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.aomed.org/prolo-therapy>

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Prolotherapy Page(s): 99-100.

**Decision rationale:** The California MTUS/ACOEM Guidelines do not recommend prolotherapy, as there is no evidence that provides significant benefits to placebo effects. As such, the request for initial prolotherapy consult, lumbar, is non-certified.

**TOPICAL COMPOUND MEDICATION OF FLURBIPROFEN 20%, TRAMADOL 20% 30 GRAMS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment.

**Decision rationale:** The California MTUS/ACOEM guidelines recommend topical analgesics to treat primarily osteoarthritic and neuropathic pain. Guidelines state that any compounded product containing at least 1 drug or drug class that is not recommended, deems the entire product not recommended. The current request contains flurbiprofen, which is not currently recommended by guidelines, as the FDA has approved diclofenac 1% as the only NSAID recommended for topical use. In addition, topical tramadol is only recommended for the treatment of postherpetic neuralgia and open skin lesions. As neither of these compounded formulations are approved by guidelines, the current request for topical compound medication of flurbiprofen 20%, tramadol 20%, 30 grams is non-certified.

**MEDROX PATCH:** 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): 111-113.

**Decision rationale:** The California MTUS/ACOEM guidelines recommend topical analgesics to treat primarily osteoarthritic and neuropathic pain. Guidelines state that any compounded product containing at least 1 drug or drug class that is not recommended, deems the entire product not recommended. The current request for Medrox is a combination cream containing menthol 5% and capsaicin 0.0375%. The California Guidelines do not recommend capsaicin in a formulation greater than 0.025%, as there is no evidence of increased efficacy. As the current request contains a formulation of capsaicin that is not recommended, the entire compounded medication is not recommended. Furthermore, there was no indication in the current request regarding the amount of patches desired. As such, the request for Medrox patch is non-certified.

**TOPICAL COMPOUND MEDICATION OF CAPSASIN 0.025%, FLURIBPRFOEN 30%, METHYL 4% 30 GRAMS:** Upheld

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

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

**Decision rationale:** The California MTUS/ACOEM guidelines recommend topical analgesics to treat primarily osteoarthritic and neuropathic pain. Guidelines state that any compounded product containing at least 1 drug or drug class that is not recommended, deems the entire product not recommended. The current request contains a formulation of flurbiprofen, which is a topical NSAID. California Guidelines and the FDA currently support the use of 1 topical NSAID, diclofenac 1%, only. As other topical NSAIDs are not recommended for use, the entire requested compound is deemed not recommended. As such, the request for topical compound medication of capsaicin 0.025%, flurbiprofen 30%, methyl 4% 30 grams is non-certified.