

Case Number:	CM14-0000842		
Date Assigned:	01/22/2014	Date of Injury:	07/10/2013
Decision Date:	06/10/2014	UR Denial Date:	12/09/2013
Priority:	Standard	Application Received:	01/02/2014

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 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 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 injured worker is a 46 year old female who reported an injury on 07/10/2013 secondary to pulling cable. The clinical note dated 11/25/2013 reported the injured worker complained of lower back pain, right shoulder pain, psychiatric complaints and sleeping problems. The lumbar spine physical examination revealed tenderness to palpation with spasms, decreased range of motion, a positive straight leg raise on the left at 45 degrees, deep tendon reflexes of the left lower extremity 1+/2+ and motor strength rated 4/5. There was decreased sensation to the left lower extremity from the thigh to the foot. The diagnoses included thoracic strain/sprain, L4-L5 disc protrusion with annular tear, right shoulder strain/sprain. The treatment plan included recommendations for medications and therapies to include acupuncture, cold therapy, an interferential unit, and an EMG/NCV was recommended as well. The injured worker's medication regimen included Cyclobenzaprine, Motrin, Tramadol, and Lodine. The injured worker has participated in approximately eight sessions of physical therapy. An MRI dated 10/23/2013 reported findings of a large far right lateral disc protrusion extending into the right neural foramen at L4-L5 compressing the right L4 nerve root, degenerative spondylosis of L3-L4 mild bilateral foraminal narrowing secondary to a broad based disc protrusion extending into both neural foramen. The request for authorization was submitted on 11/25/2013.

IMR ISSUES, DECISIONS AND RATIONALES

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

NCV BILATERAL LOWER EXTREMITIES: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

Decision rationale: The injured worker has a history of low back pain treated with physical therapy and medications. The Official Disability Guidelines state nerve conduction studies are not recommended for low back pain and there is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. The clinical information provided for review clearly showed evidence the injured worker has findings of radiculopathy, to include symptoms of decreased motor strength and sensation to the lower extremities. Therefore, the request for NCV of the bilateral lower extremities is not medically necessary and appropriate.

IF UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines Page(s): 189.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines section on Interferential Current Stimulation Page(s): 118-119.

Decision rationale: The injured worker has a history of low back pain treated with physical therapy and medications. The MTUS Chronic Pain Guidelines state Interferential Units are not recommended as an isolated intervention and there is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. The clinical information provided for review reported the injured worker is participating in physical therapy with functional improvement and following a medication regimen; however, the provider failed to specify the body area for use with this unit and length of time this unit would be required. Additionally, it was unclear if the injured worker has undergone a one month trial with the unit and its efficacy. Therefore, the request is not medically necessary and appropriate.

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, Continuous Flow Cryotherapy.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

Decision rationale: The injured worker has a history of low back pain treated with physical therapy and medications. The Official Disability Guidelines do not recommend cold compression therapy in the shoulder, as there are no published studies; however. As the Guidelines state cold compression therapy may be an option for other body parts, there was no frequency, duration or

area of use for the proposed treatment. Therefore, the request for a cryotherapy unit is not medically necessary and appropriate.

FUNCTIONAL CAPACITY EVALUATION: 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 Official Disability Guidelines (ODG), Fitness For Duty, Functional Capacity Evaluation (FCE).

Decision rationale: The injured worker has a history of low back pain treated with physical therapy and medications. The Official Disability Guidelines recommend functional capacity evaluation base on prior unsuccessful return to work attempts, conflicting medical reporting on precautions and/or fitness for modified job and injuries that require detailed exploration of a worker's ability. Additionally the guidelines recommend the injured worker be close or at maximum medical improvement and additional/secondary conditions clarified. The clinical information provided for review states the injured worker has been recommended to continue with physical therapy as a treatment to improve functional improvement and will continue to follow up for evaluations. There is no documentation stating the injured worker has unsuccessfully attempted to return to work or she is close or at maximum medical improvement. In addition, the provider failed to document a clear rationale for the request for a functional capacity evaluation. Therefore, the request for a Functional Capacity Evaluation is not medically necessary and appropriate.

ACUPUNCTURE X12: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The injured worker has a history of low back pain treated with physical therapy and medications. The MTUS Acupuncture Medical treatment Guidelines indicate acupuncture is used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. The Guidelines recommend a time to produce functional improvement of three to six treatments. The Guidelines recommend a frequency of one to three times per week and duration of one to two months. The clinical information provided for review states the injured worker has been recommended to continue with physical therapy as a treatment to improve functional improvement; however, there is no documentation stating the injured worker is intolerant of the medications prescribed or her medications have been decreased. In addition, the request for 12 sessions of acupuncture exceeds the Guidelines' recommendation of three to six treatments to produce functional improvement. Therefore, the request is not medically necessary and appropriate.

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 section on Muscle Relaxants Page(s): 63-64.

Decision rationale: The injured worker has a history of low back pain treated with physical therapy and medications. The MTUS Chronic Pain Guidelines recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. The guidelines also show efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. Based on the clinical information submitted for review, there is documented spasm and trigger points to the injured worker's shoulder; however the injured worker has been utilizing this medication since at least 10/2013. The efficacy of the medication was unclear within the medical records. In addition, there was no frequency or quantity for the proposed treatment. Therefore, request for Cyclobenzaprine is not medically necessary and appropriate.

LODINE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (Non-Steroidal Anti-Inflammatory Drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

Decision rationale: Lodine is a non-steroidal anti-inflammatory medication. The injured worker has a history of low back pain treated with physical therapy and medications. The MTUS Chronic Pain Guidelines recommended NSAIDs at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. The clinical information includes documentation indicating the injured worker has been utilizing NSAIDs since approximately 10/2013; however, there is no documentation of pain relief or improved function with the medication. In addition, there was no quantity, or frequency for the requested treatment. Therefore, the request for Lodine is not medically necessary and appropriate.