

Case Number:	CM14-0107867		
Date Assigned:	08/01/2014	Date of Injury:	08/02/2013
Decision Date:	09/17/2014	UR Denial Date:	07/01/2014
Priority:	Standard	Application Received:	07/11/2014

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 Pain Medicine, 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 61-year-old female who reported an injury on 08/02/2013. The mechanism of injury was not provided. Past treatments included medications, topical creams, and diagnostic imaging. Her diagnoses included status post left tibial fracture, poor healing. Pertinent diagnostic studies were not provided. Pertinent surgical history included left tibial fracture (with poor healing). On 06/06/2014, the injured worker was experiencing symptoms of pain to the left knee. The pain was persistent, pulling, aching, burning, numbing, and tingling in the left leg from mid-thigh to mid-calf. She was working full time doing a desk job. She had been going to physical therapy, exercises, and does house chores. The injured worker stated that she has tried Vicodin but it made her sick. She took Ibuprofen occasionally. There were no current medications provided. There are no significant changes in the objective findings. She was staying functional, working full time, and continuing with her exercise. The treatment plan was to try Biofreeze; continue with Ibuprofen; authorize acupuncture therapy 2 times a week for 4 weeks, (the injured worker had never had acupuncture for the left leg pain and it may give some relief for the symptoms.); and request for authorization of an EMG/NCS in the lower extremity. The request is for acupuncture sessions (left leg), EMG of the left lower extremity, NCS of the left lower extremity, retrospective use of Biofreeze DOS 06/16/2014, and prospective usage of Biofreeze. The rationale for acupuncture is stated above. The request for authorization was dated 06/25/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Acupuncture Sessions (Left Leg): Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment in Workers' Compensation.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The request for Acupuncture Sessions (Left Leg) is not medically necessary. The injured worker has a history of persistent left knee pain. The California MTUS Guidelines recommend that acupuncture is 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 recommended frequency of treatments is 1 to 3 times per week with functional improvement noted in 3 to 6 treatments. The optimum duration of treatments is 1 to 3 months. Acupuncture treatments may be extended if functional improvement is documented. The injured worker has not received acupuncture for the left leg. The injured worker received physical therapy, exercises, yet her symptoms continue. The patient is on minimal medications for the pain. There is no medical necessity for acupuncture at this time. There is lack of documentation as to the number of acupuncture sessions requested. As such, the request is not medically necessary.

Electromyography of the Left Lower Extremity: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment in Worker's compensation.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310.

Decision rationale: The request for EMG of the left lower extremity is not medically necessary. The injured worker has a history of persistent left knee pain. The CA MTUS/ACOEM guidelines recommend the detection of physiologic abnormalities; if no improvement after 1 month, consider needle EMG and H-reflex tests to clarify nerve root dysfunction. The guidelines do not recommend an EMG for clinically obvious radiculopathy. There is lack of documentation of evidence of neurological defect in a specific determined distribution. There is lack of documentation of positive neural tension sign indicating nerve root pathology or peripheral nerve entrapment. Without clear evidence of a neurologic defect or physical examination, the medical necessity for EMG of the lower extremity is not established. As such, the request is not medically necessary.

Nerve Conduction Study of the Left Lower Extremity: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment in Worker's Compensation.

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

Decision rationale: The request for Nerve Conduction Study of the left lower extremity is not medically necessary. The injured worker has a history of persistent left knee pain. The ACOEM guidelines should include general observations of the patient, including changes in position, stance and gait, a regional examination of the cervical spine, examination of the organ systems related to appropriate differential diagnosis possibilities, neurologic examination, testing for cervical nerve root tension, monitoring pain behavior during range of motion and while seated as a clue to origin of the problem and head protrusion (lower cervical flexion) and retraction (lower cervical extension) positions and repeated movements to determine symptom response. The guidelines further recommend the importance of determining whether or not there is cervical nerve root compromise. There is lack of evidence of neurological defect in a specific determined distribution. There is lack of documentation of positive neural tension sign indicating nerve root pathology or peripheral nerve entrapment. Without clear evidence of neurologic defect or physical exam, the medical necessity of NCS of the lower extremity is not established. As such, the request is not medically necessary.

Retrospective usage of Biofreeze: Upheld

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

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

Decision rationale: The request for retrospective usage of Biofreeze (DOS 6-16-2014) is not medically necessary. The injured worker has a history of persistent left knee pain. CA MTUS guidelines refer to Topical Analgesics as largely experimental 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. Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, Opioids, Capsaicin, Local Anesthetics, Antidepressants, Glutamate Receptor Antagonists, Alpha-Adrenergic Receptor Agonist, Adenosine, Cannabinoids, Cholinergic Receptor Agonists, Gamma Agonists, Prostanoids, Bradykinin, Adenosine Triphosphate, Biogenic Amines and nerve growth factor). There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The injured worker experiences persistent pain in the left leg from mid-thigh to mid-calf. There is no documentation that the injured worker has failed first line medication treatments such as Antidepressants or Anticonvulsant medications. There is lack of documentation for the medical necessity for Biofreeze. As such, the request is not medically necessary.

Prospective usage of Biofreeze: Upheld

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

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

Decision rationale: The request for prospective usage of Biofreeze is not medically necessary. The injured worker has a history of persistent left knee pain. CA MTUS guidelines refer to Topical Analgesics as largely experimental 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. Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, Opioids, Capsaicin, Local Anesthetics, Antidepressants, Glutamate Receptor Antagonists, Alpha-Adrenergic Receptor Agonist, Adenosine, Cannabinoids, Cholinergic Receptor Agonists, Gamma Agonists, Prostanoids, Bradykinin, Adenosine Triphosphate, Biogenic Amines and nerve growth factor). There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The injured worker experiences persistent pain in the left leg from mid-thigh to mid-calf. There is no documentation that the injured worker has failed first line medication treatments such as antidepressants or anticonvulsant medications. There is lack of documentation for the medical necessity for Biofreeze. As such, the request is not medically necessary.