

<b>Case Number:</b>	CM14-0154196		
<b>Date Assigned:</b>	09/24/2014	<b>Date of Injury:</b>	06/29/2014
<b>Decision Date:</b>	11/24/2014	<b>UR Denial Date:</b>	08/29/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/15/2014

### 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 and Rehabilitation and is licensed to practice in 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 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:

Medical records reflect the claimant is a 47 year old female who sustained a work injury on 6-20-14. On this date, the claimant was lifting boxes filled with files and developed right low back pain. The claimant has undergone 6 physical therapy sessions. The claimant has low back pain and right thigh pain. The claimant is also being prescribed with medications. Office visit on 6-2-14 notes the claimant reports low back pain, right leg discomfort. She has right leg muscle spasms, no edema, weakness or heaviness. She has no numbness or tingling. The claimant is not taking any medications at the time. On exam, the claimant has no neurological deficits. No GI problems. Diagnosis included muscle spasms, right hamstring injury, lumbosacral strain. Medications recommended. Office visit on 6-9-14 notes the claimant is to continue with physical therapy and consider MRI of the distal hamstring if not improved. On exam, the claimant had a 6 cm x 6 cm area of induration -hematoma vs. muscle spasm or tear. The claimant had tenderness to palpation over posterior thigh.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Acupuncture three times a week for six weeks:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** CA MTUS/ACOEM guidelines stress the importance of a time-limited treatment plan with clearly defined functional goals, with frequent assessment and modification of the treatment plan based upon the patient's progress in meeting those goals, and monitoring from the treating physician is paramount. In addition, Acupuncture Medical Treatment Guidelines state that acupuncture may be 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. Furthermore, guidelines state that time to produce functional improvement of 3 - 6 treatments. Based on the records provided, acupuncture is not indicated, as pain generators have not been established.

**Chiropractic treatment, three times a week for six weeks: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manipulation Page(s): 58. Decision based on Non-MTUS Citation Pain chapter manipulation

**Decision rationale:** Chronic Pain Medical Treatment Guidelines notes that Recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. ODG reflects that manipulation is recommended for chronic pain if caused by musculoskeletal conditions, only when manipulation is specifically recommended by the provider in the plan of care, if also recommended as an option in the Low Back Chapter and the Neck Chapter. Manual therapy and manipulation, also known as chiropractic treatment, are passive interventions that are considered adjuncts to other recommended treatment, especially active interventions (e.g. exercise). There is an absence in documentation noting that this claimant's pain generators have been established. Therefore, the medical necessity of this request is not established.

**Physical therapy three times a week for six weeks: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**Decision rationale:** Chronic Pain Medical Treatment Guidelines as well as ODG notes that one should allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. The claimant had been provided 6 physical therapy sessions. There is an absence in documentation noting that this claimant cannot perform a home

exercise program. There are no extenuating circumstances to support physical therapy at this juncture. Therefore, the medical necessity of this request is not established.

**Shockwave therapy, three treatments for the right thigh: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Knee and leg chapter - shockwave therapy

**Decision rationale:** ODG notes that shockwave therapy is under study for patellar tendinopathy and for long-bone hypertrophic nonunions. In the first study of this therapy for management of chronic patellar tendinopathy, extracorporeal shockwave therapy seemed to be safer and more effective, with lower recurrence rates, than conventional conservative treatments, according to results of a recent small, randomized controlled trial. (Wang, 2007) New research suggests that extracorporeal shock-wave therapy (ESWT) is a viable alternative to surgery for long-bone hypertrophic nonunions. However, the findings need to be verified, and different treatment protocols as well as treatment parameters should be investigated, including the number of shock waves used, the energy levels applied and the frequency of application. (Cacchio, 2009) New data presented at the American College of Sports Medicine Meeting suggest that extracorporeal shockwave therapy (ESWT) is ineffective for treating patellar tendinopathy, compared to the current standard of care emphasizing multimodal physical therapy focused on muscle retraining, joint mobilization, and patellar taping. (Zwerver, 2010). There is an absence in documentation noting that this claimant has a condition for which this form of treatment is recommended. Therefore, the medical necessity of this request is not established.

**Functional Capacity Evaluation: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Functional improvement measures Page(s): 48.

**Decision rationale:** Chronic Pain Medical Treatment Guidelines as well as ODG notes that functional improvement measures for chronic pain is used to consider return to normal quality of life. The importance of an assessment is to have a measure that can be used repeatedly over the course of treatment to demonstrate improvement of function, or maintenance of function that would otherwise deteriorate. There is an absence in documentation noting that there needs to be an assessment is to have a measure that can be used repeatedly over the course of treatment to demonstrate improvement of function, or maintenance of function that would otherwise deteriorate. Therefore, the medical necessity of this request is not established.

**Localized intense stimulation therapy, once a week for six weeks for the lumbar spine: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines transcutaneous electrotherapy Page(s): 114. Decision based on Non-MTUS Citation Low back chapter - hyperstimulation analgesia

**Decision rationale:** ODG notes that hyperstimulation analgesia is not recommended until there are higher quality studies. There is an absence in documentation noting that this claimant's condition requires treatment that is not recommended per current treatment guidelines. Therefore, based on the records provided, the medical necessity of this request is not established.

**X-rays for the lumbar spine:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**Decision rationale:** ACOEM X-ray is recommended for acute low back pain with red flags for fracture or serious systemic illness, subacute low back pain that is not improving, or chronic low back pain as an option to rule out other possible conditions. This claimant's physical exam does not support that she has a red flag condition or physical exam findings to support x-rays of the lumbar spine. Therefore, based on the records provided, the medical necessity of this request is not established.

**X-ray for right thigh:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Knee and leg chapter - radiography

**Decision rationale:** ODG Indications for imaging -- X-rays:- Acute trauma to the knee, fall or twisting injury, with one or more of following: focal tenderness, effusion, inability to bear weight. First study.- Acute trauma to the knee, injury to knee  $\geq$  2 days ago, mechanism unknown. Focal patellar tenderness, effusion, able to walk.- Acute trauma to the knee, significant trauma (e.g., motor vehicle accident), suspect posterior knee dislocation.- Nontraumatic knee pain, child or adolescent - nonpatellofemoral symptoms. Mandatory minimal initial exam. Anteroposterior (standing or supine) & Lateral (routine or cross-table).- Nontraumatic knee pain, child or adult: patellofemoral (anterior) symptoms. Mandatory minimal initial exam. Anteroposterior (standing or supine), Lateral (routine or cross-table), & Axial (Merchant) view.- Nontraumatic knee pain, adult: nontrauma, nontumor, nonlocalized pain. Mandatory minimal initial exam. Anteroposterior (standing or supine) & Lateral (routine or cross-table). (ACR, 2001) (Pavlov, 2000) This claimant's physical exam does not support that she has a red flag

condition or physical exam findings to support x-rays of the right thigh. Therefore, based on the records provided, the medical necessity of this request is not established.

**Ultrasound of right thigh:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation knee and leg chapter - diagnostic ultrasound

**Decision rationale:** ODG notes that diagnostic ultrasound is recommended as indicated below. Soft-tissue injuries (meniscal, chondral surface injuries, and ligamentous disruption) are best evaluated by MR. In addition to MR, sonography has been shown to be diagnostic for acute anterior cruciate ligament (ACL) injuries in the presence of a hemarthrosis or for follow-up. Medical Records does not support that this claimant has a pathology that current evidence based medicine supports to perform this diagnostic testing. Therefore, the medical necessity of this request is not established.

**TENS unit purchase with supplies:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS Unit Page(s): 114-117. Decision based on Non-MTUS Citation Pain chapter - TENS unit

**Decision rationale:** Chronic Pain Medical Treatment Guidelines as well as ODG notes that a TENS unit is not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration. This modality is recommended for conditions such as spasticity, multiple sclerosis, neuropathic pain, phantom limb pain. There is an absence in documentation noting that this claimant has had a trial with daily pain diaries noting functional and documented improvement. There is an absence in documentation she has any of these conditions for which a one month trial would be considered. Therefore, the medical necessity of this request is not established.

**Hot/Cold Unit Purchase:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation knee and leg chapter - cold/heat packs

**Decision rationale:** ODG notes that cold/heat packs are recommended. Ice massage compared to control had a statistically beneficial effect on ROM, function and knee strength. Cold packs

decreased swelling. Hot packs had no beneficial effect on edema compared with placebo or cold application. Ice packs did not affect pain significantly compared to control in patients with knee osteoarthritis. However, there is an absence in documentation noting that one requires specialized equipment to provide hot and cold treatments. Therefore, the medical necessity of this request is not established.

**Deprizine:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation US National library of medicine

**Decision rationale:** Ranitidine is used Short-term treatment of active duodenal ulcer. There is an absence in documentation noting that this claimant has GI effects secondary to the use of medications. Therefore, the medical necessity of this request is not established.

**Dicopanol:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation US National library of medicine

**Decision rationale:** Dicopanol is a brand name medication included in a group of medications called Aminoalkyl ethers. This medication is sued for the following: Parkinson Symptoms, Parkinson's Disease, Extrapyrimal Reaction, Allergic Conjunctivitis, Inflammation of the Nose due to an Allergy, Stuffy Nose, Itching, Welt from Pressure on Skin, Hives, Sensation of Spinning or Whirling, Chronic Trouble Sleeping, Sneezing, Cough, Nausea and Vomiting, Feel Like Throwing Up, Throwing Up, Motion Sickness, Life Threatening Allergic Reaction, Reaction due to an Allergy. There is an absence in documentation noting that this claimant has any of the conditions for which this medication is prescribed. Therefore, the medical necessity of this request is not established.

**Fanatrex:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines anti convulsants. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter Pain chapter - anti convulsants

**Decision rationale:** Fanatrex is Gabapentin. Chronic Pain Medical Treatment Guidelines as well as ODG reflect that anti-epileptics are recommended for neuropathic pain. There is an absence in documentation noting that this claimant has objective findings of radiculopathy on exam or that he has neuropathy. Therefore, the medical necessity of this request is not established.

**Synapryn:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol Page(s): 113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter - Tramadol

**Decision rationale:** Synapryn is Tramadol oral suspension. Chronic Pain Medical Treatment Guidelines reflect that Tramadol (Ultram) is a centrally acting synthetic opioid analgesic and it is not recommended as a first-line oral analgesic. There is an absence in documentation noting the claimant has failed first line of treatment or that she requires opioids at this juncture. Therefore, the medical necessity of this request is not established.