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| Case Number: | CM14-0161222 | | |
| Date Assigned: | 10/23/2014 | Date of Injury: | 08/25/2014 |
| Decision Date: | 11/26/2014 | UR Denial Date: | 09/18/2014 |
| Priority: | Standard | Application Received: | 10/01/2014 |

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, has a subspecialty in Interventional Spine 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 patient is a 34 year old male with an injury date of 08/25/14. The 09/04/14 first report by [REDACTED] states that the patient presents with back pain radiating to both lower extremities, tailbone (left side) pain and left hip pain. The patient is temporarily totally disabled until 10/09/14. Examination shows tenderness to palpation, spasm and trigger points in the bilateral mid/lower thoracic regain with decreased range of motion. There is lumbar spine tenderness to palpation of the spinal processes L2-L5, the bilateral paraspinal muscles and the bilateral gluteal muscles. There are also spasms to the bilateral paraspinal and gluteal muscles with decreased range of motion and a positive straight leg raise. Examination also shows left hip tenderness to palpation laterally, decreased "DTR" of the bilateral knees and ankles with decreased sensation bilateral anterolateral thigh/anterior knee/medial leg and foot and left lateral thigh/anterolateral leg/mid dorsal foot/anterolateral thigh/anterior knee, medial leg and foot and left later thigh/anterolateral leg/mid dorsal foot. The patient's diagnoses include lumbosacral musculoligamentous strain/sprain with radiculitis; rule out lumbosacral spine discogenic disease;and left bilateral hip strain/sprain vs. lumbar radiculitis. Medications started are listed as Cyclobenzaprine, Motrin, Fluriflex and TGHOT. The utilization review being challenged is dated 09/17/14. The rationale regarding EMG/NCS nerve studies is that it is an acute injury and there is no indication of observation and no examination for focal power and found only diffuse stocking distribution sensory loss. Regarding the MRI lumbar it is that there is no clear indication of focal neurological defect 3 weeks post injury. One report from 09/04/14 was provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy evaluation and treatment 12 sessions for the thoracic/lumbar spine and left hip: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 99.

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

Decision rationale: The provider requests for Physical therapy evaluation and treatment, 12 sessions for the thoracic, lumbar spine and left hip. MTUS pages 98, 99 state that for myalgia and myositis 9-10 visits are recommended over 8 weeks. For Neuralgia, neuritis and radiculitis 8-10 visits are recommended. The provider does not discuss this request; however, it appears treatment is being sought for treatment of a painful recent injury. Information is limited as only the examination of 09/04/14 is provided. There is no indication of prior physical therapy or that the patient is within a postoperative treatment period. In this case, however, the request is for 12 sessions which is more than allowed per MTUS. Therefore, this request is not medically necessary.

EMG/NCV studies of bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

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 - Lumbar & Thoracic (Acute & Chronic) chapter, Electrodiagnostic studies (EDS)

Decision rationale: The provider requests for EMG/NCV studies of bilateral lower extremities. Official Disability Guidelines, EMG/NCS topic, state this testing is recommended depending on indications and EMG and NCS are separate studies and should not necessarily be done together. Official Disability Guidelines further states, "...NCS is not recommended, but EMG is recommended as an option (needle, not surface) to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious." In this case, the patient's lifting and fall injury is recent and only the initial treatment report of 09/04/14 is provided. The provider does not discuss the reason for this request. The report shows subjective pain radiation from the back to the lower extremities, positive straight leg raise as well as tenderness to palpation and spasm to the bilateral paraspinal muscles and a diagnosis of lumbosacral sprain strain with radiculitis. However, Official Disability Guidelines states that NCS is not recommended and 1 month of conservative therapy is not documented. Therefore, this request is not medically necessary.

MRI of the lumbar spine: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

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 - Lumbar & Thoracic (Acute & Chronic) chapter, MRIs (magnetic resonance imaging)

Decision rationale: The provider requests for MRI of the lumbar spine. Official Disability Guidelines state that for uncomplicated back pain MRIs are recommended for radiculopathy following at least one month of conservative treatment. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation)." The patient's lifting and fall injury is recent and only the initial report of 09/04/14 is provided. The provider does not discuss the reason for this request. There is no indication of a prior MRI or back surgery for this patient. The patient has radicular symptoms and a positive straight leg raise and a diagnosis of radiculitis. Therefore, this request is medically necessary.

Interferential Unit: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

Decision rationale: The provider requests for Interferential unit. MTUS pages 118 to 120 states that Interferential Current Stimulation (ICS) are not recommended as an isolated intervention. MTUS further states, "While not recommended as an isolated intervention, Patient selection criteria if Interferential stimulation is to be used anyway." It may be appropriate if pain is not effectively controlled due to diminished effectiveness or side effects of medication; history of substance abuse, significant pain due to postoperative conditions; or the patient is unresponsive to conservative measures. A one month trial may be appropriate if the above criteria are met. In this case the patient injury is recent and only the 09/04/14 report is provided. The provider does not discuss the reason for this request. The treatment plan indicates that this is not intended as an isolated intervention as medication is prescribed and physical therapy is requested. However, there is no indication that pain is not effectively controlled by medication or is unresponsive to conservative measures per MTUS. Therefore, this request is not medically necessary.

Hot/Cold Unit: 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 Official Disability Guidelines (ODG) Continuous cold therapy (CCT), Carpal Tunnel Syndrome (Acute & Chronic)

Decision rationale: The provider requests for Hot/cold unit. MTUS is silent on hot/cold therapy units. Official Disability Guidelines Carpal Tunnel Section discusses Continuous Cold Therapy for post-operative Carpal Tunnel treatment. The provider does not discuss the reason for this request. There is no recommendation by Official Disability Guidelines or documentation or discussion for the use and efficacy of the requested device for the back, lower extremities or hip. Therefore, this request is not medically necessary.

Lumbosacral Brace: 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 Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic Chapter, lumbar supports topic

Decision rationale: The provider requests for Lumbosacral brace. MTUS Chronic Pain Medical Treatment Guidelines do not discuss lumbar brace. ACOEM Chapter 12 guidelines do not recommend it. Official Disability Guidelines Low Back - Lumbar & Thoracic Chapter, lumbar supports topic, states, "Recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific LBP (very low-quality evidence, but may be a conservative option)." In this case, the reports provided do not show the above conditions in this patient to support this request. Therefore, this request is not medically necessary.

Urine toxicology: 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 Official Disability Guidelines (ODG), Pain (Chronic) chapter, Urine drug testing (UDT)

Decision rationale: The provider requests for Urine toxicology. While MTUS Guidelines do not specifically address how frequent UDS should be obtained for various risks of opiate users, Official Disability Guidelines provide clearer recommendation. It recommends once yearly urine screen following initial screening with the first 6 months for management of chronic opiate use in low risk patient. The provider does not discuss this request in the report provided. On 09/04/14 the treatment rendered section shows that prescription was given for Fluriflex and TGHOT topical medications and Cyclobenzaprine (a muscle relaxant) and Motrin (an NSAID). Due to the lack of documented opioid use, this request is not medically necessary.

TG Hot 180g: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, Topical Creams Page(s): 111, 112.

Decision rationale: The provider requests for TG Hot 180 g. The MTUS Topical analgesics pages 111 and 112 have the following regarding topical creams: "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." This is a compound topical medication containing Tramadol, Gabapentin, Menthol and Camphor. In this case Tramadol is not supported for topical formulation. MTUS specifically states that Gabapentin is not recommended under the topical cream section. Therefore, this request is not medically necessary.

FluriFlex topical ointment 180g: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-112.

Decision rationale: The patient presents with "back pain radiating to both lower extremities", left side tailbone and left hip pain. The provider requests for FluriFlex topical ointment. The MTUS Topical analgesics pages 111 and 112 have the following regarding topical creams: "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." FluriFlex is a Cyclobenzaprine cream. In this case Cyclobenzaprine is not supported for topical formulation. Therefore, this request is not medically necessary.