MAXIMUS Federal Services

Case Number:	CM14-0057143		
Date Assigned:	08/06/2014	Date of Injury:	03/18/2013
Decision Date:	11/20/2014	UR Denial Date:	02/07/2014
Priority:	Standard	Application Received:	03/07/2014

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 Family Practice 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 claimant is a 34 year old male who sustained a work injury on 2/11/13 involving the back. He was diagnosed with thoracic and lumbar spine herniated nucleus pulposus with radiculitis. A progress note on 11/30/13 indicated the claimant had 7/10 back pain that was aggravated with activities. Exam findings were notable for limited range of motion of the spine with a positive Kemp's and straight leg raise test. Motor strength was reduced to 4/5 in all muscle groups. The physician prescribed a TENS unit, 18 sessions of physical therapy, EMG/NCV of the lower extremities, Heat/Cold unit, compounded topical medications: Deprizine, Dicopanol, Fanatrex, Synapryn, Tabradol, Cyclophene, Ketoprofen cream, X-rays/MRI of the thoracic/lumbar spine, functional capacity evaluation, 18 sessions of acupuncture, and 6 sessions of shock wave therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS unit and supplies: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS unit Page(s): 116.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 113-115.

Decision rationale: According to the MTUS Chronic Pain Medical Treatment Guidelines, 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. It is recommended for the following diagnoses: CRPS, multiple sclerosis, spasticity due to spinal cord injury and neuropathic pain due to diabetes or herpes. In this case, the claimant did not have the above diagnoses. The length of use was not specified. The request for a TENS unit is not medically necessary.

Compound medications: Deprizine, Dicopanol, Fanatrex, Synapryn, Tabradol, Cyclophene, Ketoprofen cream: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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

Decision rationale: According to the MTUS Chronic Pain Medical Treatment Guidelines, topical analgesics are recommended as an option as indicated below. They are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. There is insufficient evidence on the use of any of the topical medications above. Specific utilization, treatment response and length of use were not specified in the notes. The above topical compounds are not medically necessary.

X-rays thoracic and lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181-183. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

Decision rationale: According to the ACOEM guidelines, x-rays are recommended when there are red flags for fracture. In this case, the injury was remote. There was no indication of a recent injury, fracture or red flag symptoms. The x-rays are not medically necessary.

MRI thoracic and lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

Decision rationale: According to the ACOEM guidelines, an MRI of the lumbar spine is recommended for red flag symptoms such as cauda equina, tumor, infection, or uncertain neurological diagnoses not determined or equivocal on physical exam. In this case, the injury was remote. There was no indication of a recent injury, fracture or red flag symptoms. The MRIs are not medically necessary.

EMG/NCS of bilateral lower extremities: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back pain

Decision rationale: According to the ACOEM guidelines, an EMG is not recommended for clinically obvious radiculopathy. It is used to clarify nerve root dysfunction. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. In this case, the exam findings are consistent with the history of radiculopathy. The EMG or NCV would not change the clinical management and there is limited evidence to support its use. The request is not medically necessary.

Functional capacity evaluation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Chapter 7 Independent medical examinations and consultations, page 132-139

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 48. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Functional Capacity, page 175

Decision rationale: According to the guidelines, activities at work that increase symptoms need to be reviewed and modified. A functional capacity evaluation is indicated when information is required about a worker's functional abilities that is not available through other means. It is recommended that wherever possible should reflect a worker's capacity to perform the physical activities that may be involved in jobs that are potentially available to the worker. In this case there is no mention of returning to work or description of work duties that require specific evaluation. No documentation on work hardening is provided. As a result, a functional capacity evaluation is not medically necessary.

Acupuncture three times per 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: According to the MTUS Acupuncture Medical Treatment Guidelines, 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. Frequency and duration of acupuncture or acupuncture with electrical stimulation may be performed as follows:Time to produce functional improvement: 3 to 6 treatments.In this case, functional/pain response is not known prior to requesting 18 sessions of acupuncture. The request above exceeds the amount recommended by the guidelines and is not medically necessary.

Physical therapy three times per week for six weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine guidelines Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines

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

Decision rationale: According to the MTUS Chronic Pain Medical Treatment Guidelines, therapy is recommended in a fading frequency. They 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 following diagnoses have their associated recommendation for number of visits:Myalgia and myositis, unspecified 9-10 visits over 8 weeksNeuralgia, neuritis, and radiculitis, unspecified 8-10 visits over 4 weeksReflex sympathetic dystrophy (CRPS) 24 visits over 16 weeksIn this case, functional/pain response is not known prior to requesting 18 sessions of physical therapy. The request above exceeds the amount recommended by the guidelines and is not medically necessary.

Six sessions of Shock wave therapy: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Back pain and Shock therapy

Decision rationale: According to the guidelines, the available evidence does not support the effectiveness of ultrasound or shock wave for treating low back pain. In the absence of such evidence, the clinical use of these forms of treatment is not justified and should be discouraged.

The specific indication for application was not specified in the notes. Based on insufficient evidence to support its use, the shock wave therapy is not medically necessary.

Hot/Cold unit: Upheld

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

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

Decision rationale: According to the ACOEM guidelines, local heat/cold is optional for at home applications. According to the Official Disability Guidelines, heat/cold therapy is an option and can be helpful in pain reduction. In this case, the claimant's pain is chronic. There is insufficient evidence to support heat/cold unit in chronic back pain. Therefore, this request is not medically necessary.