MAXIMUS Federal Services

Case Number:	CM14-0074033		
Date Assigned:	08/08/2014	Date of Injury:	12/25/2013
Decision Date:	09/26/2014	UR Denial Date:	04/11/2014
Priority:	Standard	Application Received:	05/21/2014

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 Orthopedic Surgery 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:

This is a 61-year-old who sustained a vocational injury on December 15, 2013 when he was carrying a box of meat into a freezer and slipped and fell. The medical records provided for review documented diagnoses of lumbosacral musculoskeletal ligamentous sprain/strain with radiculitis, rule out lumbosacral spine discogenic disease, left shoulder strain/sprain, left shoulder tendinosis, left shoulder impingement syndrome, rule out left shoulder rotator cuff tear, left elbow sprain/strain, left elbow lateral epicondylitis, left wrist sprain/strain, rule out left wrist carpal tunnel syndrome, depression, and sleep disturbance secondary to pain. It is documented that on March 26, 2014 the claimant complained of left shoulder pain, left arm pain, low back pain, psychiatric complaints and sleeping disorders. Physical examination was documented to show tenderness of the lumbar spine bilaterally about the paraspinal muscles and sacroiliac joints, sciatic notch, posterior iliac crest and gluteal muscles. There were spasms of the bilateral paraspinal muscles, gluteal muscles. Range of motion was decreased. He had a positive straight leg raise on the right at 45 degrees. He had left shoulder tenderness to palpation, anterior/posterior as well as along the rotator cuff. He had decreased range of motion noted about the left shoulder with positive Neer and supraspinatus test. The left elbow had tenderness to palpation anteriorly. He had a positive Cozen's test. There was left wrist tenderness to palpation of the dorsal aspect. There were positive Tinel's/Phalen's tests. There were decreased deep tendon reflexes bilaterally. The biceps, triceps and brachioradialis were noted to be 1+ out of 2+. There was decreased motor strength of the left upper extremity at 4/5 and decreased sensation in the median nerve distribution. There was decreased motor strength in the right lower extremity at 4/5 and decreased sensation of the right anterolateral thigh/anterior knee/medial leg. The medical records did not identify any conservative measures offered since the date of injury.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI lumbosacral 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.

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); Low back chapter: MRIs (magnetic resonance imaging)Recommended for indications below. MRI's are test of choice for patients with prior back surgery, but for uncomplicated low back pain, with radiculopathy, not recommended until after at least one month conservative therapy, sooner if severe or progressive neurologic deficit. 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). (Bigos, 1999) (Mullin, 2000) (ACR, 2000) (AAN, 1994) (Aetna, 2004) (Airaksinen, 2006) (Chou, 2007) Magnetic resonance imaging has also become the mainstay in the evaluation of myelopathy. An important limitation of magnetic resonance imaging in the diagnosis of myelopathy is its high sensitivity. The ease with which the study depicts expansion and compression of the spinal cord in the myelopathic patient may lead to false positive examinations and inappropriately aggressive therapy if findings are interpreted incorrectly. (Seidenwurm, 2000) There is controversary over whether they result in higher costs compared to X-rays including all the treatment that continues after the more sensitive MRI reveals the usual insignificant disc bulges and herniations. (Jarvik-JAMA, 2003) In addition, the sensitivities of the only significant MRI parameters, disc height narrowing and anular tears, are poor, and these findings alone are of limited clinical importance. (Videman, 2003) Imaging studies are used most practically as confirmation studies once a working diagnosis is determined. MRI, although excellent at defining tumor, infection, and nerve compression, can be too sensitive with regard to degenerative disease findings and commonly displays pathology that is not responsible for the patient's symptoms. With low back pain, clinical judgment begins and ends with an understanding of a patient's life and circumstances as much as with their specific spinal pathology. (Carragee, 2004) Diagnostic imaging of the spine is associated with a high rate of abnormal findings in asymptomatic individuals. Herniated disk is found on magnetic resonance imaging in 9% to 76% of asymptomatic patients; bulging disks, in 20% to 81%; and degenerative disks, in 46% to 93%. (Kinkade, 2007) Baseline MRI findings do not predict future low back pain. (Borenstein, 2001) MRI findings may be preexisting. Many MRI findings (loss of disc signal, facet arthrosis, and end plate signal changes) may represent progressive age changes not associated with acute events. (Carragee, 2006) MRI abnormalities do not predict poor outcomes after conservative care for chronic low back pain patients. (KleinstÃ¼ck, 2006) The new ACP/APS guideline as compared to the old AHCPR guideline is more forceful about the need to avoid specialized diagnostic imaging such as magnetic resonance imag

Decision rationale: The ACOEM Guidelines state that lumbar spine x-rays are considered first-line diagnostic treatment in claimants that have failed a reasonable course of conservative

treatment to include four to six weeks. It is recommended that relying solely on imaging studies to evaluate the source of low back and related symptoms carries a significant risk of diagnostic confusion because of the possibility of identifying a finding that was present before symptoms began and therefore has not temporal association with the symptoms. The Official Disability Guidelines recommend MRIs for thoracic or lumbar spine trauma, uncomplicated low back pain with associated radiculopathy after at least one month of documented conservative treatment, uncomplicated low back pain in the setting of prior lumbar surgery or cauda equina syndrome, or myelopathy. There is no documentation in the medical records provided for review that the claimant has attempted, failed and exhausted traditional first-line conservative treatment options or that the claimant has had plain radiographs, which are considered first-line diagnostic study of choice prior to considering an MRI for the lumbar spine. Therefore, the request for an MRI of the lumbar spine is not medically necessary or appropriate.

MRI left shoulder: 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 9 Shoulder Complaints Page(s): 207-209. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Shoulder chapter: Magnetic resonance imaging (MRI)Recommended as indicated below. Magnetic resonance imaging (MRI) and arthrography have fairly similar diagnostic and therapeutic impact and comparable accuracy, although MRI is more sensitive and less specific. Magnetic resonance imaging may be the preferred investigation because of its better demonstration of soft tissue anatomy. (Banchard, 1999) Subtle tears that are full thickness are best imaged by MR arthrography, whereas larger tears and partial-thickness tears are best defined by MRI, or possibly arthrography, performed with admixed gadolinium, which if negative, is followed by MRI. (Oh, 1999) The results of a recent review suggest that clinical examination by specialists can rule out the presence of a rotator cuff tear, and that either MRI or ultrasound could equally be used for detection of full-thickness rotator cuff tears. (Dinnes, 2003) Shoulder arthrography is still the imaging "gold standard" as it applies to full-thickness rotator cuff tears, with over 99% accuracy, but this technique is difficult to learn, so it is not always recommended. Magnetic resonance of the shoulder and specifically of the rotator cuff is most commonly used, where many manifestations of a normal and an abnormal cuff can be demonstrated. The question we need to ask is: Do we need all this information? If only full-thickness cuff tears require an operative procedure and all other abnormalities of the soft tissues require arthroscopy, then would shoulder arthrography suffice? (Newberg, 2000) Ultrasonography and magnetic resonance imaging have comparable high accuracy for identifying biceps pathologies and rotator cuff tears, and clinical tests have modest accuracy in both disorders. The choice of which imaging test to perform should be based on the patient's clinical information, cost, and imaging experience of the radiology department. (Ardic, 2006) MRI is the most useful technique for evaluation of shoulder pain due to subacromial impingement and rotator cuff disease and can be used to diagnose bursal inflammatory change, structural causes of impingement and secondary tendinopathy, and partial- and full-thickness rotator cuff tears. However, The overall prevalence of tears of the rotator cuff on MRI is 34% among symptom-free patients of all age groups, being 15% for full-thickness tears and 20% for

partial-thickness tears. The results of this study support the use of MRI of the shoulder before injection both to confirm the diagnosis and to triage affected patients to those likely to benefit (those without a cuff tear) and those not likely to benefit (those with a cuff tear). (Hambly, 2007) The preferred imaging modality for patients with suspected rotator cuff disorders is MRI. However, ultrasonography may emerge as a cost-effective alternative to MRI. (Burbank, 2008) Primary care physicians are making a significant amount of inappropri

Decision rationale: The Shoulder Complaints Chapter of the ACOEM Practice Guidelines suggest the claimant should fail a four to six week period of conservative care and observation prior to considering or recommending the request for diagnostic imaging in the form of an MRI. The medical records do not document any concerns that the claimant has instability or there has been a significant change in symptoms and/or findings suggestive of significant pathology. The Official Disability Guidelines support the ACOEM Guideline recommendations. Therefore, the request for an MRI of the left shoulder is not medically necessary or appropriate.

x-ray left shoulder: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Shoulder chapter: RadiographyRecommended as indicated below. The acutely traumatized shoulder should be imaged with plain films that are orthogonal to each other. Shoulder arthrography is still the imaging "gold standard" as it applies to full-thickness rotator cuff tears, with over 99% accuracy, but this technique must be learned, so it is not always recommended. (Newberg, 2000) Plain radiographs should be routinely ordered for patients with chronic shoulder pain, including anteroposterior, scapular Y, and axillary views. Radiographs of the acromioclavicular joint can be difficult to interpret because osteoarthritis of this joint is common by the age of 40 to 50 years. The preferred imaging modality for patients with suspected rotator cuff disorders is MRI. However, ultrasonography may emerge as a cost-effective alternative to MRI. (Burbank, 2008)Indications for imaging -- Plain radiographs:- Acute shoulder trauma, rule out fracture or dislocation- Acute shoulder trauma, questionable bursitis, blood calcium (Ca+)/approximately 3 months duration, first study.

Decision rationale: The ACOEM Guidelines and supported by the Official Disability Guidelines recommend that claimants should have a documented four to six week period of conservative treatment and observation with failure to improve symptoms prior to recommending and considering plain radiographs. In addition, there should be documentation of acute shoulder trauma to rule out fracture or dislocation and currently there is no mention of concerns of such. Therefore, the request for an X-ray of the left shoulder is not medically necessary or appropriate.

Electromyogram (EMG) bilateral upper 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 8 Neck and Upper Back Complaints Page(s): 177-179. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Neck and Upper Back chapter: Electrodiagnostic studies (EDS)See also Nerve conduction studies (NCS) and Electromyography (EMG). Electrodiagnostic studies should be performed by appropriately trained Physical Medicine and Rehabilitation or Neurology physicians. For more information and references, see the Carpal Tunnel Syndrome Chapter. Below are the Minimum Standards from that chapter.Minimum Standards for electrodiagnostic studies: The American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM) recommends the following minimum standards:(1) EDX testing should be medically indicated. (2) Testing should be performed using EDX equipment that provides assessment of all parameters of the recorded signals. Studies performed with devices designed only for "screening purposes" rather than diagnosis are not acceptable. (3) The number of tests performed should be the minimum needed to establish an accurate diagnosis. (4) NCSs (Nerve conduction studies) should be either (a) performed directly by a physician or (b) performed by a trained individual under the direct supervision of a physician. Direct supervision means that the physician is in close physical proximity to the EDX laboratory while testing is underway, is immediately available to provide the trained individual with assistance and direction, and is responsible for selecting the appropriate NCSs to be performed. (5) EMGs (Electromyography - needle not surface) must be performed by a physician specially trained in electrodiagnostic medicine, as these tests are simultaneously performed and interpreted. (6) It is appropriate for only 1 attending physician to perform or supervise all of the components of the electrodiagnostic testing (e.g., history taking, physical evaluation, supervision and/or performance of the electrodiagnostic test, and interpretation) for a given patient and for all the testing to occur on the same date of service. The reporting of NCS and EMG study results should be integrated into a unifying diagnostic impression. (7) In contrast, dissociation of NCS and EMG results into separate reports is inappropriate unless specifically explained by the physician. Performance and/or interpretation of NCSs separately from that of the needle EMG component of the test should clearly be the exception (e.g. when testing an acute nerve injury) rather than an established practice pattern for a given practitioner. (AANEM, 2009)Electromyography (EMG)Recommended (needle, not surface) as an option in selected cases. The American Association of Electrodiagnostic Medicine conducted a review on electrodiagnosis in relation to cervical radiculopathy and concluded that the test was moderately sensitive (50%-71%) and highly specific (65%-85%). (AAEM, 1999) EMG findings may not be predictive of surgical outcome in cervical surgery, and patients may still benefit from surgery even in the absence of EMG findings of nerve

Decision rationale: The California ACOEM Guidelines and supported by the Official Disability Guidelines recommend conservative treatment for a period of four to six weeks prior to recommending and considering further diagnostic studies. Therefore, the request for an EMG of the bilateral upper extremities is not medically necessary or appropriate.

Nerve Conduction Velocity (NCV) bilateral upper 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 8 Neck and Upper Back Complaints Page(s): 177-179. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Neck and Upper Back chapter: Electrodiagnostic studies (EDS)See also Nerve conduction studies (NCS) and Electromyography (EMG). Electrodiagnostic studies should be performed by appropriately trained Physical Medicine and Rehabilitation or Neurology physicians. For more information and references, see the Carpal Tunnel Syndrome Chapter. Below are the Minimum Standards from that chapter.Minimum Standards for electrodiagnostic studies: The American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM) recommends the following minimum standards:(1) EDX testing should be medically indicated. (2) Testing should be performed using EDX equipment that provides assessment of all parameters of the recorded signals. Studies performed with devices designed only for "screening purposes" rather than diagnosis are not acceptable. (3) The number of tests performed should be the minimum needed to establish an accurate diagnosis. (4) NCSs (Nerve conduction studies) should be either (a) performed directly by a physician or (b) performed by a trained individual under the direct supervision of a physician. Direct supervision means that the physician is in close physical proximity to the EDX laboratory while testing is underway, is immediately available to provide the trained individual with assistance and direction, and is responsible for selecting the appropriate NCSs to be performed. (5) EMGs (Electromyography - needle not surface) must be performed by a physician specially trained in electrodiagnostic medicine, as these tests are simultaneously performed and interpreted. (6) It is appropriate for only 1 attending physician to perform or supervise all of the components of the electrodiagnostic testing (e.g., history taking, physical evaluation, supervision and/or performance of the electrodiagnostic test, and interpretation) for a given patient and for all the testing to occur on the same date of service. The reporting of NCS and EMG study results should be integrated into a unifying diagnostic impression. (7) In contrast, dissociation of NCS and EMG results into separate reports is inappropriate unless specifically explained by the physician. Performance and/or interpretation of NCSs separately from that of the needle EMG component of the test should clearly be the exception (e.g. when testing an acute nerve injury) rather than an established practice pattern for a given practitioner. (AANEM, 2009)Nerve conduction studies (NCS)Not recommended to demonstrate radiculopathy if radiculopathy has already been clearly identified by EMG and obvious clinical signs, but recommended if the EMG is not clearly radiculopathy or clearly negative, or to differentiate radiculopathy from other neuropathies or non-neuropathic processes if other diagnoses may be likely based on the clinical exam. There is minimal justification for performing nerve conduction studies when a patient is already presume

Decision rationale: The California ACOEM Guidelines and supported by the Official Disability Guidelines recommend conservative treatment for a period of four to six weeks prior to recommending and considering further diagnostic studies. The medical records provided for review do not identify that the claimant has attempted, failed and exhausted conservative treatment prior to recommending and considering further diagnostic studies. Therefore, the request for an NCV of the bilateral upper extremities is not medically necessary or appropriate.

Electromyogram (EMG) 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): 303-305. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Low Back chapter: Electrodiagnostic studies (EDS)See also Nerve conduction studies (NCS) which are not recommended for low back conditions, and EMGs (Electromyography) which are recommended as an option for low back. Electrodiagnostic studies should be performed by appropriately trained Physical Medicine and Rehabilitation or Neurology physicians. For more information and references, see the Carpal Tunnel Syndrome Chapter. Below are the Minimum Standards from that chapter.Minimum Standards for electrodiagnostic studies: The American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM) recommends the following minimum standards:(1) EDX testing should be medically indicated (i.e., to rule out radiculopathy, lumbar plexopathy, peripheral neuropathy). (2) Testing should be performed using EDX equipment that provides assessment of all parameters of the recorded signals. Studies performed with devices designed only for "screening purposes" rather than diagnosis are not acceptable. (3) The number of tests performed should be the minimum needed to establish an accurate diagnosis. (4) NCSs (Nerve conduction studies) should be either (a) performed directly by a physician or (b) performed by a trained individual under the direct supervision of a physician. Direct supervision means that the physician is in close physical proximity to the EDX laboratory while testing is underway, is immediately available to provide the trained individual with assistance and direction, and is responsible for selecting the appropriate NCSs to be performed. (5) EMGs (Electromyography - needle not surface) must be performed by a physician specially trained in electrodiagnostic medicine, as these tests are simultaneously performed and interpreted. (6) It is appropriate for only 1 attending physician to perform or supervise all of the components of the electrodiagnostic testing (e.g., history taking, physical evaluation, supervision and/or performance of the electrodiagnostic test, and interpretation) for a given patient and for all the testing to occur on the same date of service. If both tests are done, the reporting of NCS and EMG study results should be integrated into a unifying diagnostic impression. (7) If both tests are done, dissociation of NCS and EMG results into separate reports is inappropriate unless specifically explained by the physician. Performance and/or interpretation of NCSs separately from that of the needle EMG component of the test should clearly be the exception (e.g. when testing an acute nerve injury) rather than an established practice pattern for a given practitioner. (AANEM, 2009) Note: For low back NCS are not recommended and EMGs are recommended in some cases, so generally they would not both be covered in a report for a low back condition.EMGs (electromyography)Recommended as an option (needle, not surface). EMGs (electromyography) may be useful to obtain unequivo

Decision rationale: The California ACOEM Guidelines and supported by the Official Disability Guidelines recommend conservative treatment for a period of four to six weeks prior to recommending and considering further diagnostic studies. The medical records do not document that the claimant has attempted, failed and exhausted conservative treatment prior to recommending and considering further diagnostic studies. Therefore, the request for an EMG of the bilateral lower extremities is not medically necessary or appropriate.

Nerve Conduction Velocity (NCV) 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): 303-305. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Low Back chapter: Electrodiagnostic studies (EDS)See also Nerve conduction studies (NCS) which are not recommended for low back conditions, and EMGs (Electromyography) which are recommended as an option for low back. Electrodiagnostic studies should be performed by appropriately trained Physical Medicine and Rehabilitation or Neurology physicians. For more information and references, see the Carpal Tunnel Syndrome Chapter. Below are the Minimum Standards from that chapter.Minimum Standards for electrodiagnostic studies: The American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM) recommends the following minimum standards:(1) EDX testing should be medically indicated (i.e., to rule out radiculopathy, lumbar plexopathy, peripheral neuropathy). (2) Testing should be performed using EDX equipment that provides assessment of all parameters of the recorded signals. Studies performed with devices designed only for "screening purposes" rather than diagnosis are not acceptable. (3) The number of tests performed should be the minimum needed to establish an accurate diagnosis. (4) NCSs (Nerve conduction studies) should be either (a) performed directly by a physician or (b) performed by a trained individual under the direct supervision of a physician. Direct supervision means that the physician is in close physical proximity to the EDX laboratory while testing is underway, is immediately available to provide the trained individual with assistance and direction, and is responsible for selecting the appropriate NCSs to be performed. (5) EMGs (Electromyography - needle not surface) must be performed by a physician specially trained in electrodiagnostic medicine, as these tests are simultaneously performed and interpreted. (6) It is appropriate for only 1 attending physician to perform or supervise all of the components of the electrodiagnostic testing (e.g., history taking, physical evaluation, supervision and/or performance of the electrodiagnostic test, and interpretation) for a given patient and for all the testing to occur on the same date of service. If both tests are done, the reporting of NCS and EMG study results should be integrated into a unifying diagnostic impression. (7) If both tests are done, dissociation of NCS and EMG results into separate reports is inappropriate unless specifically explained by the physician. Performance and/or interpretation of NCSs separately from that of the needle EMG component of the test should clearly be the exception (e.g. when testing an acute nerve injury) rather than an established practice pattern for a given practitioner. (AANEM, 2009) Note: For low back NCS are not recommended and EMGs are recommended in some cases, so generally they would not both be covered in a report for a low back condition.Nerve conduction studies (NCS)Not recommended. There is minimal justification for performing nerve conduction studies when a pa

Decision rationale: The California ACOEM Guidelines and supported by the Official Disability Guidelines recommend conservative treatment for a period of four to six weeks prior to recommending and considering further diagnostic studies. The medical records provided for review do not identify that the claimant has attempted, failed and exhausted conservative treatment prior to recommending and considering further diagnostic studies. Therefore, the request for an NCV of the bilateral lower extremities is not medically necessary or appropriate.

functional capacity evaluation: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management. Decision based on Non-MTUS Citation The California ACOEM Guidelines and supported by the Official Disability Guidelines recommend a functional capacity evaluation prior to admission to a work hardening program. There is no documentation that the claimant will be entering a work hardening program. In addition, the intended purpose of the FCE is not clearly noted, which would be important to know prior to considering medical necessity. It is also not clear from the medical records why diagnostic evaluations are being requested at the same time an FCE is requested. Therefore, the request for a functional capacity evaluation is not medically necessary or appropriate.

Decision rationale: The request for a functional capacity evaluation (FCE) is not recommended as medically necessary. The California ACOEM Guidelines and supported by the Official Disability Guidelines recommend a functional capacity evaluation prior to admission to a work hardening program. There is no documentation that the claimant will be entering a work hardening program. In addition, the intended purpose of the FCE is not clearly noted, which would be important to know prior to considering medical necessity. It is also not clear from the medical records why diagnostic evaluations are being requested at the same time an FCE is requested. Therefore, based on the documentation presented for review and in accordance with Official Disability Guidelines, the request for the functional capacity evaluation cannot be considered medically necessary.

urine toxicology screen: 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 Chronic Pain Treatment Guidelines Opioids, differentiation: dependence & addiction Page(s): 85.

Decision rationale: It is noted that a previous urine toxicology screen was performed on April 3, 2014 and was negative for any of the substances that were tested. There is no documentation that the claimant is receiving any medications which would require urine toxicology screening to include Benzodiazepines, muscle relaxers, illegal substances or narcotics. Therefore, the request for a urine toxicology screen is not medically necessary or appropriate.

lumbosacral brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 301.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

Decision rationale: The California ACOEM Guidelines state that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. Documentation suggests that the claimant's injury was greater than nine months ago and subsequently the request for a lumbar support is not well understood. Therefore, the request for a lumbosacral brace is not medically necessary or appropriate.

interferential unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 117-121.

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

Decision rationale: The Chronic Pain Guidelines state that interferential current stimulation is not recommended as an isolated intervention. Prior to proceeding with an interferential unit, the claimants should have documentation that they have failed traditional first-line conservative treatment options such as antiinflammatories, a home exercise program, activity modification, formal physical therapy and transcutaneous electrotherapy. The medical records do not described the conservative treatment that has been offered to the claimant. The claimant does not meet criteria set forth by California Chronic Pain Medical Treatment Guidelines. Therefore, the request for an interferential unit is not medically necessary or appropriate.

hot/cold therapy 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.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Low Back chapter: Cold/heat packsRecommended as an option for acute pain. At-home local applications of cold packs in first few days of acute complaint; thereafter, applications of heat packs or cold packs. (Bigos, 1999) (Airaksinen, 2003) (Bleakley, 2004) (Hubbard, 2004) Continuous low-level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. (Nadler 2003) The evidence for the application of cold treatment to low-back pain is more limited than heat therapy, with only three poor quality studies located that support its use, but studies confirm that it may be a low risk low cost option. (French-Cochrane, 2006) There is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful for pain reduction and return to normal function. (Kinkade, 2007).

Decision rationale: The California ACOEM Guidelines recommend the application of cold or heat at home for discomfort. The Official Disability Guidelines support the use of cold and heat packs as an option for acute pain at home local applications of cold ice in the first few days and acute complaints thereafter are considered medically reasonable. Currently, there is no

indication for continuous cold/heat therapy. Therefore, the request for a hot/cold therapy unit is not medically necessary or appropriate.

physical therapy times 12: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 98-99.

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

Decision rationale: The claimant's injury occurred nine months ago. The Chronic Pain Medical Treatment Guidelines support eight to ten visits of physical therapy over four weeks for myalgia, neuralgia and like disorders. The request for 12 therapy visits exceed the recommended ten visits per California Chronic Pain Medical Treatment Guidelines. Therefore, the request for twelve sessions of physical therapy is not medically necessary or appropriate.

Fluriflex 180 g: Upheld

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

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

Decision rationale: According to the Chronic Pain Guidelines, topical analgesics are considered largely experimental and should only be considered after traditional first-line conservative treatment options have failed to provide any significant relief such as antiinflammatories, activity modification, formal physical therapy and a home exercise program. The medical records provided for review do not identify that the claimant has attempted, failed and exhausted all traditional first-line conservative treatment options prior to recommending considering a topical analgesic such as FluriFlex. Subsequently, the request for Fluriflex 180 grams is not medically necessary or appropriate.

TG Hot 180 g: Upheld

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

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

Decision rationale: According to the Chronic Pain Guidelines, topical analgesics are considered largely experimental and should only be considered after traditional first-line conservative treatment options have failed to provide any significant relief such as antiinflammatories, activity modification, formal physical therapy and a home exercise program. The medical records provided for review do not identify that the claimant has attempted, failed and exhausted all

traditional first-line conservative treatment options prior to recommending considering a topical analgesic such as TGHot. Subsequently, the request for TGHot 180 grams is not medically necessary or appropriate.