

Case Number:	CM14-0089373		
Date Assigned:	08/06/2014	Date of Injury:	10/11/2012
Decision Date:	09/30/2014	UR Denial Date:	06/09/2014
Priority:	Standard	Application Received:	06/13/2014

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 Pain Medicine and is licensed to practice in Ohio and 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:

The injured worker is a 50-year-old female who reported an injury of unknown mechanism on 10/11/2012. The clinical data submitted is handwritten and difficult to read. On 05/05/2014 her diagnoses included cervical spine disc pro/dd/NCV/EMG, thoracic spine disc pro/lipoma, lumbar spine herniated nucleus pulposus with FS, bilateral wrist/hand, right carpal tunnel syndrome/cyst, left hip (illegible), left knee chondro/meniscal tear, hypertension, insomnia, and stress. The only legible complaint was constant left knee pain. Pain in the cervical spine was rated 8/10, pain in the thoracic spine was rated 5/10, pain in the lumbar spine was rated 1/10, bilateral wrist and hand pain was rated 7/10, left hip pain rated was 1/10 and left knee pain was rated 9/10. In the treatment plan there was a note to continue chiropractic and topical creams as prescribed, shockwave max, and nothing else was legible. There was no rationale or Request for Authorization included in this injured worker's chart.

IMR ISSUES, DECISIONS AND RATIONALES

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

12 Chiropractic treatments, lumbar region: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-60.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-60.

Decision rationale: The request for 12 Chiropractic treatments, lumbar region, is not medically necessary. The California MTUS Guidelines recommend manual therapy and manipulation for chronic pain if caused by musculoskeletal conditions. For low back pain, it is recommended as an option. The recommendations are a trial of 6 visits over 2 weeks with evidence of objective functional improvement. The requested 12 visits exceed the recommendations in the guidelines. Therefore, this request for 12 chiropractic treatments, lumbar region, is not medically necessary.

Tramadol ER 150mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 93-94, 113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-95.

Decision rationale: The request for tramadol ER 150mg #30 is not medically necessary. The California MTUS Guidelines recommend that a therapeutic trial of opioids should not be employed until the patient has failed a trial of nonopioid analgesics. Baseline pain and functional assessments should be made. Function should include social, physical, psychological, daily and work activities, and should be performed using a validated instrument or numerical rating scale. The patient should have at least 1 physical and psychosocial assessment by the treating doctor and a possible second opinion by a specialist to assess whether a trial of opioids should occur. There was no documentation submitted that this injured worker has failed trials of nonopioid analgesics. There was no documentation of previous use of any opioids for pain relief. There was no documentation submitted of psychosocial assessment. Additionally, there was no frequency of administration included in the request. The clinical information submitted failed to meet the evidence based guidelines for opioid trials. Therefore, this request for tramadol ER 150 mg #30 is not medically necessary.

8 Shockwave treatments, lumbar region: 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, Low Back-Lumbar & Thoracic (Acute & Chronic).

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, Shock wave therapy.

Decision rationale: The request for 8 Shockwave treatments, lumbar region, is not medically necessary. The Official Disability Guidelines do not recommend shockwave therapy for the low back. The available evidence does not support the effectiveness of ultrasound or shockwave treatment for lower back pain. In the absence of such evidence, the clinical use of these forms of

treatments is not justified and should be discouraged. The use of this requested therapy is not supported by the guidelines. Therefore, this request for 8 shockwave treatments, lumbar region, is not medically necessary.

4 NM testing, lumbar region: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303, 309.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm, Wrist, & Hand, Computerized muscle testing.

Decision rationale: The request for 4 NM testing, lumbar region, is not medically necessary. The Official Disability Guidelines do not recommend computerized muscle testing. There are no studies to support computerized strength testing. There is no useful application of such a potentially sensitive computerized test. Deficit definition is quite adequate with usual exercise equipment. Considering the physiological reality of daily performance variations which always vary in human performance, this would be an unneeded test. The requested testing is not supported by the guidelines. Therefore, this request for 4 NM testing, lumbar region, is not medically necessary.

4 NM diagnostic procedure, lumbar region: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303, 309.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Forearm, Wrist, & Hand, Computerized muscle testing.

Decision rationale: The request for 4 NM diagnostic procedure, lumbar region, is not medically necessary. The Official Disability Guidelines do not recommend computerized muscle testing. There are no studies to support computerized diagnostic testing. There is no useful application of such a potentially sensitive computerized test. Deficit definition is quite adequate with usual exercise equipment. Considering the physiological reality of daily performance variations which always vary in human performance, this would be an unneeded test. The requested procedure is not supported by the guidelines. Therefore, this request for 4 NM diagnostic procedure, lumbar region, is not medically necessary.

Menthoderm (Salicylate 15/Menthol 10%) gel 360 grams: 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 Mentherm (Salicylate 15/Menthol 10%) gel 360 grams is not medically necessary. The California 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 for pain control including local anesthetics. There is little to no research to support the use of any of these agents. Any compounded product that contains at least 1 drug or drug class that is not recommended is not recommended. Methyl salicylate has not been evaluated by the FDA for topical use in humans. The clinical information submitted failed to meet the evidence based guidelines for topical analgesics. Therefore, this request for Mentherm (Salicylate 15/Menthol 10%) gel 360 grams is not medically necessary.