MAXIMUS Federal Services

Case Number:	CM14-0184903		
Date Assigned:	11/14/2014	Date of Injury:	11/08/2011
Decision Date:	01/21/2015	UR Denial Date:	10/29/2014
Priority:	Standard	Application Received:	11/06/2014

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 Spine Surgery, 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:

The injured worker is a 54-year-old male who reported an injury on 11/08/2011. The mechanism of injury was not clearly provided. The injured worker's diagnoses included cervical sprain/strain, right shoulder internal derangement, low back pain, lumbar spine sprain/strain. The injured worker's past treatments included medications. The injured worker's diagnostic testing included an x-ray of the left shoulder, performed on 08/21/2014, which was noted to reveal degenerative marginal osteophyte off the articular surface of the acromion. An MRI of the lumbar spine, performed on 08/18/2014, was noted to reveal postsurgical changes at L5 down through S1 consistent with posterior surgical fusion, associated with the fusion hardware which cast metallic artifact in the region. An MRI of the cervical spine, performed on 08/18/2014, was noted to reveal mild disc desiccation at C2-3 down to C6-7. The injured worker's surgical history included a spinal fusion. On 09/24/2014, the injured worker complained of radicular neck pain and muscle spasms. He rated his pain 8/10 on the pain scale. He also complained of right shoulder pain radiating down the arm to the fingers, associated with muscle spasms. He rated this pain 6/10 to 7/10 on the pain scale. He reported radicular low back pain and muscle spasms. He rated the pain 8/10 on the pain scale. He reported that the medications offer him temporary relief of pain and improve his ability to have restful sleep. Upon physical examination, the cervical spine was noted with decreased range of motion with flexion limited at 25 degrees, extension at 40 degrees. His right shoulder range of motion was also noted to be limited with flexion at 160 degrees and abduction at 170 degrees. His motor strength was noted at 4/5 in all the represented muscle groups in the bilateral upper extremities. He was noted with slightly decreased sensation to pinprick and light touch at the L4, L5, and S1 dermatomes bilaterally. The lumbar spine had limited range of motion with flexion at 50 degrees and extension at 20 degrees. The injured worker's medications included Deprizine, Dicopanol, Fanatrex, Synapryn, Tabradol,

Cyclobenzaprine, and Ketoprofen cream. The request was for an x-ray of the cervical spine, x-ray of the right shoulder, x-ray of the lumbar spine, ESWT treatments to the right shoulder x3, EXSWT treatments to the cervical and lumbar spine x 6, acupuncture visits for the cervical and lumbar spine and the right shoulder x18, MRI of the cervical spine, MRI of the lumbar spine, MRI of the right shoulder, EMG/NCV of the bilateral upper extremities, EMG/NCV of the bilateral lower extremities, chiropractic manipulation visits for the cervical spine, lumbar spine, and the right shoulder x18, localized intense neurostimulation therapy for the lumbar spine, TENS unit with supplies, and Ketoprofen cream. The rationale for these requests was not clearly provided. The Request for Authorization form was signed and submitted on 09/24/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

X-ray of the cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

Decision rationale: The request for x-ray of the cervical spine is not medically necessary. According to the California MTUS/ACOEM Guidelines, for most patients presenting with true neck or upper back problems, special studies are not needed unless a 3 or 4 week conservative care and observation fails to improve the symptoms. Criteria for ordering imaging studies include an emergence of a red flag, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. The injured worker complained of radicular neck pain and spasms that he rated an 8/10 on the pain scale. However, upon physical examination, there were no significant objective neurological deficits documented. In the absence of documentation with significant objective neurological deficits, and emergence of a red flag documented, and failure to progress in a strengthening program, the request is not supported. Therefore, the request is not medically necessary.

X-ray of the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209.

Decision rationale: The request for x-ray of the right shoulder is not medically necessary. According to the California MTUS/ACOEM Guidelines, for most patients with shoulder problems, special studies are not needed unless a 4 or 6 week conservative care and observation fail to improve the symptoms. The primary criteria for ordering imaging studies include an emergence of a red flag, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program. The injured worker complained of burning right shoulder pain radiating down the arm to the fingers, associated with muscle spasms. He rated the pain a 6/10 to 7/10 on the pain scale. Upon physical examination, the right shoulder was noted with some limited range of motion with flexion at 160 degrees and abduction at 170 degrees. Sensation to pinprick and light touch is intact. In the absence of documentation with significant objective functional limitations, documented evidence of an emergence of a red flag, documented evidence of physiologic evidence of tissue insult or neurovascular dysfunction, and evidence of tried and failed conservative care (to include physical therapy, home exercise program, and medications), the request is not supported. Therefore, the request is not medically necessary.

X-ray of the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303, 308.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: The request for x-ray of the lumbar spine is not medically necessary. According to the California MTUS/ACOEM Guidelines, lumbar spine x-rays should not be recommended in the patient with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least 6 weeks. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment. The injured worker complained of burning, radicular low back pain and muscle spasms that he rated an 8/10 on the pain scale. Upon physical examination of the lumbar spine, there was slightly decreased sensation to pinprick and light touch at the L4, L5, and S1 dermatomes bilaterally. Documentation did not provide sufficient evidence of tried and failed conservative therapy (to include physical therapy, home exercise program, medications). In the absence of documentation with sufficient evidence of tried and failed conservative therapy and documented evidence of red flags for serious spinal pathology, the request is not supported. Therefore, the request is not medically necessary.

Extracorporal Shockwave therapy treatments to the right shoulder x 3: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 203. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Extracorporeal shock wave therapy (ESWT)

Decision rationale: The request for Extracorporeal Shockwave Therapy treatments to the right shoulder x 3 is not medically necessary. According to the Official Disability Guidelines, ESWT may be recommended for calcifying tendinitis, but not for other shoulder disorders. The injured worker complained of right shoulder pain radiating down the arm to the fingers, that he rated a 6/10 to 7/10 on the pain scale. However, in the absence of documented evidence of calcifying tendinitis, the request is not supported. Therefore, the request is not medically necessary.

Extracorporal Shockwave Therapy treatments to the cervical and lumbar spine x 6: 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) Low Back - Lumbar & Thoracic

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, Shockwave therapy

Decision rationale: The request for Extracorporeal Shockwave Therapy treatments to the cervical and lumbar spine x 6 is not medically necessary. The Official Disability Guidelines indicate ESWT is not recommended in the lumbar spine. There were no guidelines to support the use of extracorporeal shockwave therapy treatments to the cervical or lumbar spine. In the absence of such evidence, the clinical use of these forms of treatment is not justified and should be discouraged. Therefore, the request is not medically necessary.

Acupuncture visits for the cervical and lumbar spine and the right shoulder x 18: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 204,Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The request for acupuncture visits for the cervical and lumbar spine and the right shoulder x 18 is not medically necessary. According to the California MTUS Acupuncture 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. Documentation did not provide sufficient evidence of a reduction in pain medication or an intolerance to pain medication. The documentation did not indicate that the acupuncture would be used as an adjunct to physical rehabilitation. In the absence of documentation with sufficient evidence of a reduction in pain medication and documented evidence that the acupuncture will be used as an adjunct to physical rehabilitation, the request is not supported. Therefore, the request is not medically necessary.

MRI of the cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

Decision rationale: The request for MRI of the cervical spine is not medically necessary. According to the California MTUS/ACOEM Guidelines, most patients presenting with true neck or upper back problems, special studies are not needed unless a 3 or 4 week conservative care and observation fails to improve the symptoms. Criteria for ordering imaging studies include an emergence of a red flag, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. The injured worker complained of pain to the neck area with limited range of motion to the cervical spine. However, documentation did not provide sufficient evidence of an emergence of a red flag, physiologic evidence of tissue insult or neurologic dysfunction, or evidence of tried and failed conservative therapy (to include physical therapy, home exercise program, and medications). In the absence of documentation with sufficient evidence of significant objective neurological deficits, documented evidence of an emergence of a red flag, and documented evidence of tried and failed conservative therapy, the request is not supported. Therefore, the request is not medically necessary.

MRI of the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 53 and 303.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: The request for MRI of the lumbar spine is not medically necessary. According to the California MTUS/ACOEM Guidelines, unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. The injured worker was noted with slightly decreased sensation to pinprick and light touch at the L4, L5, and S1 dermatomes bilaterally. The documentation did not provide sufficient evidence of tried and failed conservative therapy (to include physical therapy, home exercise program, and medications). In the absence of documentation with sufficient evidence of tried and failed conservative therapy, the request is not supported. Therefore, the request is not medically necessary.

MRI of the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208-209.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209.

Decision rationale: The request for MRI of the right shoulder is not medically necessary. According to the California MTUS/ACOEM Guidelines, for most patients with shoulder problems, special studies are not needed unless a 4 or 6 week conservative care and observation fail to improve the symptoms. The primary criteria for ordering imaging studies include an emergence of a red flag, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program. The injured worker complained of shoulder pain and was noted with decreased range of motion to the right shoulder. The documentation did not provide sufficient evidence of an emergence of a red flag, documented evidence of physiologic evidence of tissue insult or neurovascular dysfunction, or evidence of tried and failed conservative therapy (to include physical therapy, home exercise program, and medications). In the absence of documentation with emergence of a red flag, documented evidence of physiologic tissue insult or neurovascular dysfunction, or documented evidence of tried and failed conservative therapy, the request is not supported. Therefore, the request is not medically necessary.

EMG/NCV of the bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 178 and 261.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

Decision rationale: The request for EMG/NCV of the bilateral upper extremities is not medically necessary. According to the California MTUS/ACOEM Guidelines, electromyography and nerve conduction velocities, including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than 3 or 4 weeks. The documentation did not provide sufficient evidence of tried and failed conservative therapy (to include physical therapy, home exercise program, and medications). The injured worker reported neck pain associated with numbness and tingling in the upper extremities. The injured worker underwent electrodiagnostic testing on 04/08/2013, which revealed moderate right carpal tunnel syndrome, and mild to moderate right ulnar neuropathy at the elbow. In the absence of documented evidence of tried and failed conservative care, and documented evidence of new findings suggestive of pathology that does not correlate with the previous electrodiagnostic testing, the request is not supported. Therefore, the request is not medically necessary.

EMG/NCV of the bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar and Thoracic

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: The request for EMG/NCV of the bilateral lower extremities is not medically necessary. According to the California MTUS/ACOEM Guidelines, electromyography, including H-reflex tests, may be useful to identify subtle focal neurologic dysfunction in patients with low back symptoms lasting more than 3 or 4 weeks. The injured worker was noted with slightly diminished sensation to pinprick and light touch at the L4, L5, and S1 dermatomes bilaterally. However, the documentation did not provide sufficient evidence of tried and failed conservative therapy (to include physical therapy, home exercise program, and medications). An EMG/NCV, performed on 04/02/2012 revealed evidence of low back neuropathy. An electrodiagnostic report of 04/23/2013 indicated no evidence of peripheral neuropathy at any level in the bilateral lower extremities, and an abnormal EMG demonstrated right active S1 denervation. In the absence of documentation with sufficient evidence of tried and failed conservative therapy, and documented evidence of progressive neurological deficits and new findings suggestive of pathology that does not correlate with the previous electrodiagnostic testing, the request is not supported. Therefore, the request is not medically necessary.

Chiropractic manipulation visits for the cervical spine, lumbar spine and the right shoulder x 18: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy and manipulation Page(s): 58. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder, Manipulation; Neck, Manipulation

Decision rationale: The request for chiropractic manipulation visits for the cervical spine, lumbar spine and the right shoulder x 18 is not medically necessary. According to the California MTUS Guidelines, manual therapy and manipulation may be recommended for chronic pain if caused by musculoskeletal conditions. 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. It may be recommended for the low back as an option with a trial of 6 visits over 2 weeks, and with evidence of objective functional improvement, a total of up to 18 visits over 6 to 8 weeks. The Official Disability Guidelines state there is limited evidence to specifically support the utilization of manipulative procedures of the shoulder, but these procedures are routinely applied by chiropractic providers whose scope allows it. In general, it would not be advisable to use this modality beyond 2 to 3 visits if signs of objective progress towards functional restoration are not demonstrated. The guidelines may recommend treatment for sprains and strains of the

shoulder and upper arm for up to 9 visits over 8 weeks with evidence of objective functional improvement. The Official Disability Guidelines state that in limited existing trials, cervical manipulation has fared equivocally with other treatments, like mobilization, and may be a viable option for patients with mechanical neck disorders. However, it would not be advisable to use beyond 2 to 3 weeks if signs of objective progress towards functional restoration are not documented. The guidelines may recommend up to 9 visits over 8 weeks for regional neck pain with evidence of objective functional improvement. The injured worker complained of pain in the cervical spine, lumbar spine, and right shoulder. The guidelines recommend a trial of 6 visits over 2 weeks for manipulation in the low back. The guidelines recommend a trial of 2 to 3 weeks for manipulation in the cervical spine and shoulder with the ability to continue if signs of objective functional restoration are demonstrated. As the request is written it exceeds the guidelines. Therefore, the request is not medically necessary.

Localized intense neurostimulation therapy 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) Low Back - Lumbar & Thoracic

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, Hyperstimulation analgesia

Decision rationale: The request for localized intense neurostimulation therapy for the lumbar spine is not medically necessary. The Official Disability Guidelines do not recommend hyperstimulation analgesia until there are higher quality studies. In the absence of documentation with sufficient high quality studies for localized intense neurostimulation therapy for the lumbar spine, the request is not supported. As such, the request is not medically necessary.

TENS unit with supplies: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114.

Decision rationale: The request for TENS unit with supplies is not medically necessary. According to the California MTUS Guidelines, TENS units are not recommended as a primary treatment modality, but a 1 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. Although TENS may reflect the long standing accepted standard of care within many medical communities, the results of studies are inconclusive; the published trials do not provide information on the stimulation parameters which are most likely to provide optimum pain relief, nor do they answer questions about long term effectiveness. The criteria for the use of TENS include documentation of pain of at least 3 months duration; documented evidence that other

appropriate pain modalities have been tried (including medication) and failed; documented evidence of a 1 month trial period of the TENS unit which should be documented (an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; and rental would be preferred over purchase during this trial. The injured worker did report pain, however, the documentation did not provide sufficient evidence that other appropriate pain modalities have been tried and failed. The documentation did not provide sufficient evidence of a 1 month trial period of the TENS unit or documentation of the outcomes. In the absence of documentation with sufficient evidence of tried and failed conservative therapy to include medication, and documented evidence of a 1 month trial period of the TENS unit, the request is not supported. Therefore, the request is not medically necessary.

Ketoprofen Cream (unknown prescription): Upheld

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

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

Decision rationale: The request for Ketoprofen cream (unknown prescription) is not medically necessary. The California MTUS Guidelines state that topical analgesics are largely experimental in use 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 as monotherapy or in combination for pain control. There is little to no research to support the use of many of these agents. Any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. The use of these compounded agents requires knowledge of the specific analgesic effect of each agent and how it would be useful for the specific therapeutic goal required. Ketoprofen is not currently FDA approved for topical application. It has an extremely high incidence of photo-contact dermatitis. In the absence of documentation with sufficient evidence of FDA approved status for this topical agent, the request is not supported. Additionally, as the request was written there was no frequency provided. As such, the request is not medically necessary.