

Case Number:	CM14-0193842		
Date Assigned:	12/01/2014	Date of Injury:	01/10/2001
Decision Date:	01/14/2015	UR Denial Date:	11/19/2014
Priority:	Standard	Application Received:	11/19/2014

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 Occupational Medicine, 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:

Injured worker is a female with date of injury 1/10/2001. Per primary treating physician's report dated 11/4/2014, the injured worker complains of frequent moderate low back aches described as sore, tight, sharp and rated at 7/10. She reports occasional severe right hip pain described as sharp, aches, sore, throbbing and rated at 8/10. Since her injury she has been experiencing increased tension, depression, headaches, sleeplessness, frustration, irritability and loss of interest in usual activities. She reports that six of eight activities of daily living have been compromised, including self care, physical activities, sensory function, hand function, travel and sleep. On examination, the lumbosacral spine range of motion is flexion 60 degrees, extension 20 degrees, lateral flexion 20 degrees right and left, and rotation 20 degrees right and left. There is pain in all planes. There is positive Kemps and Bechtrews on the right, and positive Elys and iliac compression bilaterally. Right hip range of motion is flexion 70 degrees, extension 0 degrees, abduction 25 degrees, and adduction 10 degrees. There is pain in all planes and there is positive hip compression and SI joints compression on the right. Diagnoses include 1) lumbar sprain/strain 2) lumbar multi-level IVD 3) lumbar disc desiccation 4) myofascitis 5) radiculitis 6) right hip sprain/strain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Evaluation and Medications: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 78, 79, 90.

Decision rationale: Per the MTUS Guidelines, the clinician acts as the primary case manager. The clinician provides medical evaluation and treatment and adheres to a conservative evidence-based treatment approach that limits excessive physical medicine usage and referral. The clinician should judiciously refer to specialists who will support functional recovery as well as provide expert medical recommendations. Referrals may be appropriate if the provider is uncomfortable with the line of inquiry, with treating a particular cause of delayed recovery, or has difficulty obtaining information or agreement to a treatment plan. The injured worker has been seeing the pain management specialist, which is reasonable. This request also mentions medications, which was clarified by the utilization review that any request for medications should be provided with adequate documentation to determine medical necessity. This request for "evaluation and medications" is not an appropriate request because it may be interpreted as medication prescriptions not requiring any further review for medical necessity. The request for Evaluation and Medications is determined to not be medically necessary.

Shockwave Therapy to Lumbar x 4: Upheld

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

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 chapter, Shock Wave Therapy section

Decision rationale: The MTUS Guidelines do not address the use of extracorporeal shock wave therapy to the lumbar spine. The ODG does not recommend the use of shock wave therapy as the available evidence does not support the effectiveness of ultrasound or shock wave for treating low back pain. The request for Shockwave Therapy to Lumbar x 4 is determined to not be medically necessary.

Chiropractic/Physiotherapy 1x4 to Lumbar/R. Hip: 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 Manual Therapy & Manipulation section Page(s): 58-61.

Decision rationale: Per the MTUS Guidelines, chiropractic care consisting of manual therapy and manipulation for the low back is recommended for chronic pain if caused by musculoskeletal conditions. Manual therapy is widely used in the treatment of musculoskeletal pain. The intended

goal or effect 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. A therapeutic trial of 6 visits over 2 weeks is recommended. If there is evidence of objective functional improvement, a total of up to 18 visits over 6 to 8 weeks is recommended. Elective or maintenance care is not recommended. Recurrences or flare ups should be evaluated for treatment success, and if return to work is achieved, 1-2 visits every 4-6 months are reasonable. The injured worker was injured 14 years ago, and the primary treating physician is a chiropractor that provides chiropractic therapy. This request is to continue such treatments at 1 time per week for 4 weeks. The medical reports do not indicate how many chiropractic treatments the injured worker has had, or efficacy of these treatments. There is no report of why chiropractic treatments are indicated at this time. The absence of such information accompanying this request indicates that these are maintenance treatments, which are not recommended by the MTUS Guidelines. There does not appear to be any recurrence or flare up that may benefit from treatments up to 1-2 visits every 4-6 months, as recommended by the MTUS Guidelines. The request for Chiropractic/Physiotherapy 1x4 to Lumbar/R. Hip: is determined to not be medically necessary.

Dendracin 120mls: 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 Capsaicin Topical section, Topical Analgesics section Page(s): 28, 29, 111-113.

Decision rationale: Dendracin lotion contains the active ingredients methyl salicylate 30%, capsaicin 0.0375%, and menthol 10%. The use of topical analgesics are recommended as an option for the treatment of chronic pain, however, any compounded product that contains at least one drug or drug class that is not recommended is not recommended. The MTUS Guidelines do recommend the use of topical capsaicin only as an option in patients who have not responded or are intolerant to other treatments. There have been no studies of a 0.0375% formulation of capsaicin and there is no current indications that this increase over a 0.025% formulation would provide any further efficacy. Since capsaicin 0.0375% is not recommended by the guidelines, the use of Dendracin lotion is not recommended. The request for Dendracin 120 mls is determined to not be medically necessary.