MAXIMUS Federal Services

Case Number:	CM15-0109372		
Date Assigned:	06/16/2015	Date of Injury:	08/06/2008
Decision Date:	11/17/2015	UR Denial Date:	05/27/2015
Priority:	Standard	Application Received:	06/05/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: California
Certification(s)/Specialty: Emergency Medicine

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 47 year old male, who sustained an industrial injury on 8/06/2008. Diagnoses include lumbar disc displacement without myelopathy, sciatica, cervical disc herniation without myelopathy and thoracic disc displacement without myelopathy. Treatment to date has included surgical intervention (lumbar fusion 12/2010 and hardware removal 1/25/2014), diagnostics, pain medications, muscle relaxants and NSAIDs and chiropractic care. Per the Primary Treating Physician's Progress Report dated 4/30/2015, the injured worker reported cervical spine pain with associated numbness in the bilateral forearms, wrists and hands and associated headaches causing blindness in the right eye. He also reported thoracic spine, shoulder pain and lumbar spine pain with associated numbness and tingling in the lower extremities. Physical examination revealed painful, decreased ranges of motion in all planes of the cervical, thoracic and lumbar spine. There was +3 spasm and tenderness to the bilateral lumbar, cervical and thoracic paraspinal muscles, multifidus and sub occipital muscles. He remains temporarily totally disabled. The plan of care included, and authorization was requested for x-rays of the lumbar spine, pain management consultation, a physical medicine program x 6 visits to include electrical muscle stimulation, infrared massage and therapeutic activities, follow-up visit with range of motion and to address activities of daily living, multi-inferential stimulator one month rental, EMG (electromyography)/NCV (nerve conduction studies) of the lower extremities, massage therapy (3x2), compound creams and a functional capacity evaluation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Medicine Program, to include electrical muscle stimulation, infrared, massage and therapeutic activities: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Title 8, California Code of Regulations, section 9792.20 et seq. (page 25), Effective July 18, 2009, (Final Version).

Decision rationale: The request is for physical medicine therapy. This is usually requested to aid in pair reduction and restoration of function. The California Code of Regulations states the following regarding this treatment for low back pathology: Postsurgical treatment (fusion): 34 visits over 16 weeks. Postsurgical physical medicine treatment period: 6 months. In this case, the patient does not qualify for physical medicine therapy. This is secondary to the remote nature of the injury with the time period elapsed. As such, the request is not medically necessary.

Follow up visit with Range of Motion and to address ADLs (activities of daily living): Upheld

Claims Administrator guideline: Decision based on MTUS Knee Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids, criteria for use.

Decision rationale: The request is for a follow-up visit with range of motion and to address activities of daily living. The MTUS guidelines states that manipulation 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 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. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. It is indicated for low back pain but not ankle and foot conditions, carpal tunnel syndrome, forearm/wrist/hand pain, or knee pain. The use of active treatment modalities instead of passive treatments is associated with substantially better clinical outcomes. (Fritz, 2007) Active treatments also allow for fading of treatment frequency along with active self-directed home PT, so that less visits would be required in uncomplicated cases. In this case, the patient would benefit most from at home self-directed therapy. As such, the request is not medically necessary.

Multi-inferential stimulator, 1 month rental: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back & thoracic, Interferential therapy.

Decision rationale: The request is for the use of Interferential therapy to aid in pain relief. It has been postulated that Interferential stimulation allows for deeper penetration of tissue, whereas TENS is predominantly a superficial stimulus. The MTUS guidelines states that this is not recommended as an isolated event with lacking quality evidence of effectiveness. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and post-operative knee pain. There is insufficient literature to support Interferential current stimulation for the treatment of these conditions. The ODG guidelines states that its use for low back pain is generally not recommended. In this case the documentation does not support the use of this treatment modality. As such, the request is not medically necessary.

EMG (electromyography)/ NCV (nerve conduction velocity) of Lower Extremities: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) EMGs (electromyography).

Decision rationale: Recommended as an option (needle, not surface), EMGs (electromyography) may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. (Bigos, 1999) (Ortiz-Corredor, 2003) (Haig, 2005) No correlation was found between intraoperative EMG findings and immediate postoperative pain, but intraoperative spinal cord monitoring is becoming more common and there may be benefit in surgery with major corrective anatomic intervention like fracture or scoliosis or fusion where there is significant stenosis. (Dimopoulos, 2004) EMGs may be required by the AMA Guides for an impairment rating of radiculopathy. (AMA, 2001) (Note: Needle EMG and H-reflex tests are recommended, but Surface EMG and F-wave tests are not very specific and therefore are not recommended. See Surface electromyography). In this case, the patient does not meet criteria for the study requested. This is secondary to the study being previously performed. As such, the request is not medically necessary.

Massage therapy, 3 times wkly for 2 wks: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, and Low Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Initial Care.

Decision rationale: The request is for massage therapy. The ACOEM guidelines state the following regarding its use for neck and upper back pain: There is no high-grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction, heat/cold applications, massage, diathermy, cutaneous laser treatment, ultrasound, transcutaneous electrical neurostimulation (TENS) units, and biofeedback. These palliative tools may be used on a trial basis but should be monitored closely. Emphasis should focus on functional restoration and return of patients to activities of normal daily living. In this case, the request is not indicated. This is secondary to poor scientific evidence regarding its effectiveness. As such, the request is not medically necessary.

Flurbiprofen 15%, Cyclobenzaprine 2%, Baclofen 2%, Lidocaine 5%, 180 gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: The request is for the use of a compounded medication for topical use to aid in pain relief. These products contain multiple ingredients which each have specific properties and mechanisms of action. The MTUS guidelines state the following: Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. In this case, the use of the topical muscle relaxant is not indicated for use for the patient's condition. The MTUS states the following: "There is no evidence for use of any other muscle relaxant as a topical product." As such, the request is not medically necessary.

Lidocaine 6%, Gabapentin 10%, Ketoprofen 10%, 180 gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: The request is for the use of a compounded medication for topical use to aid in pain relief. These products contain multiple ingredients which each have specific properties and mechanisms of action. The MTUS guidelines state the following: Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. In this case, the use of Gabapentin is stated to be not indicated for use for the patient's condition. The guidelines state the following: Gabapentin: Not recommended. There is no peer-reviewed literature to support use. As such, the request is not medically necessary.

Physical - FCE functional capacity evaluation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Fitness for Duty chapter - Functional capacity evaluation (FCE).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Functional capacity evaluation.

Decision rationale: The request is for a functional capacity evaluation. The MTUS guidelines are silent regarding this issue. The ODG state the following: Guidelines for performing an FCE: Recommended prior to admission to a Work Hardening (WH) Program, with preference for assessments tailored to a specific task or job. If a worker is actively participating in determining the suitability of a particular job, the FCE is more likely to be successful. A FCE is not as effective when the referral is less collaborative and more directive. It is important to provide as much detail as possible about the potential job to the assessor. Job specific FCEs are more helpful than general assessments. The report should be accessible to all the return to work participants. Consider an FCE if: 1) Case management is hampered by complex issues such as: Prior unsuccessful RTW attempts. Conflicting medical reporting on precautions and/or fitness for modified job. Injuries that require detailed exploration of a worker's abilities. 2) Timing is appropriate: Close or at MMI/all key medical reports secured. Additional/secondary conditions clarified. Do not proceed with an FCE if the sole purpose is to determine a worker's effort or compliance. The worker has returned to work and an ergonomic assessment has not been arranged. (WSIB, 2003) In this case a functional capacity evaluation is not indicated. There is inadequate documentation of the patient and employer actively participating in determining the suitability of a particular job. As such, the request is not medically necessary.