

<b>Case Number:</b>	CM15-0132297		
<b>Date Assigned:</b>	07/27/2015	<b>Date of Injury:</b>	04/03/2014
<b>Decision Date:</b>	09/22/2015	<b>UR Denial Date:</b>	06/29/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/08/2015

### 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: Arizona, Michigan

Certification(s)/Specialty: Preventive Medicine, Occupational 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 33 year old female, who sustained an industrial injury on 04/03/2014. She has reported subsequent low back, bilateral lower extremity and left knee pain and was diagnosed with lumbago, lumbar spine sprain/strain; rule out disc displacement, rule out lumbar radiculopathy and left knee sprain/strain; rule out derangement. Treatment to date has included medication, physical therapy and epidural injections. Documentation shows that Cyclobenzaprine was prescribed to the injured worker since at least 01/14/2015. In a progress note dated 06/04/2015, the injured worker reported burning radicular low back pain and muscle spasms and left knee pain. Pain was rated as 6/10. Objective findings were notable for palpable tenderness of the lumbar paraspinal muscles, decreased range of motion of the lumbar spine, tenderness to palpation over the medial and lateral joint line and patellofemoral joint, decreased range of motion of the left knee and slightly decreased sensation to pinprick and light touch at the L4, L5 and S1 dermatomes bilaterally. The injured worker was noted to be off work. A request for authorization of consultation with a pain management specialist regarding lumbar epidural steroid injections, transcutaneous electrical neurostimulator (TENS) unit, localized intense neurostimulation therapy for the lumbar spine, once a week for six weeks, physical therapy three times a week for six weeks, acupuncture three times a week for six weeks, chiropractic treatment for the lumbar spine and left knee three times a week for six weeks, x-rays of the lumbar spine and left knee, MRI of the lumbar spine and left knee, shockwave therapy, functional capacity evaluation (FCE), EMG/NCV of the bilateral lower extremities, Deprizine, Dicoprofol, Fanatrex, Synapryn, Tabradol, Cyclobenzaprine, Ketoprofen cream, Cyclobenzaprine

2%/Gabapentin 15%/Amitriptyline 10% 180gm and Capsaicin 0.025%/Flurbiprofen 15% was submitted.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Consultation with a pain management specialist regarding lumbar ESIs:** 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 Epidural Steroid Injections (ESIs) Page(s): 46.

**Decision rationale:** Per the MTUS, Epidural Steroid Injections are recommended as an option for the treatment of radicular pain. The purpose of the ESI is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs and avoiding surgery. The treatment alone offers no significant long-term functional benefit. Criteria for the use of Epidural steroid injections includes: 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50 percent pain relief with associated reduction of medication use for six to eight weeks with a general recommendation of no more than 4 blocks per region per year. A review of the injured workers medical records that are available to me do not reveal that the injured worker meets the criteria for ESI at this time, therefore the request for Consultation with a pain management specialist regarding lumbar ESIs is not medically necessary.

**TENS unit with supplies for home use:** 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 Transcutaneous Electrotherapy Page(s): 114-117.

**Decision rationale:** As per CA MTUS guidelines, transcutaneous electrical nerve stimulation (TENS) can be used for chronic intractable pain if there's evidence of pain for at least three months, documentation that other pain modalities had been attempted and failed and a one month trial period of the TENS with documentation as to the frequency of use and outcomes. A treatment plan with short and long term goals of treatment should also be included. There was no documentation as to which body part TENS was to be applied to, insufficient documentation of a failure of other conservative therapies, no documentation of the duration of treatment or goals for use. There is no indication that the injured worker had undergone a one month trial with TENS unit. The documentation submitted is insufficient to establish the medical necessity of the service in review. Therefore, the request for authorization of TENS is not medically necessary.

**Hot/Cold unit:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299.

**Decision rationale:** Per ACOEM in the MTUS, physical therapeutic interventions recommended include at-home local applications of cold in first few days of acute complaint, thereafter applications of heat or cold. This does not require the use of any special equipment other than what is readily available over the counter and therefore the request for hot and cold therapy unit is not medically necessary.

**Localized intense neurostimulation therapy for the lumbar spine, once a week for six weeks:** 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, Lumbar & Thoracic (Acute & Chronic), Hyperstimulation analgesia.

**Decision rationale:** CA MTUS guidelines are silent regarding the use of localized intense neurostimulation therapy so alternative guidelines were referenced. As per ODG, localized intense neurostimulation therapy is not recommended for the lumbar spine until higher quality studies are conducted. Since current guidelines do not support the use of this modality, medical necessity is not established. Therefore, the request for authorization of this service is not medically necessary.

**Physical therapy three times a week for six weeks:** 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 Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Lumbar & Thoracic (Acute & Chronic) chapter, Physical Therapy (PT) Knee & Leg (Acute & Chronic) chapter, Physical Medicine Treatment.

**Decision rationale:** As per CA MTUS guidelines for physical medicine "Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-

directed home Physical Medicine." As per Official Disability Guidelines, there is strong evidence that physical methods, including exercise and return to normal activities, have the best long-term outcome in employees with low back pain. The recommended treatment duration for a diagnosis of lumbar sprains and strains is 10 visits over 8 weeks. Physical therapy for the knee is recommended with positive, limited evidence and the recommended treatment duration for a diagnosis of knee sprain/strain is 12 visits over 8 weeks. The documentation submitted indicates that the injured worker had received previous physical therapy, however there was no specification as to the body parts for which physical therapy was administered, the number of visits received, and the effectiveness of therapy. In addition, the number of requested physical therapy visits exceeds ODG guidelines for the injured worker's diagnoses. Therefore, the request for physical therapy is not medically necessary.

**Acupuncture three times a week for six weeks: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** As per CA MTUS 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 and/or surgical intervention to hasten functional recovery." "Frequency and duration of acupuncture or acupuncture with electrical stimulation may be performed as follows: (1) Time to produce functional improvement: 3 to 6 treatments. (2) Frequency: 1 to 3 times per week. (3) Optimum duration: 1 to 2 months. (d) Acupuncture treatments may be extended if functional improvement is documented as defined in Section 9792.20(ef)." The documentation submitted indicates that 18 sessions of acupuncture were being requested for the left knee and low back. There was no documentation of intolerance or planned reduction of pain medication. In addition, the request exceeds recommended guidelines for treatment. As per guidelines, approval of any further acupuncture treatments beyond 3-6 should be contingent upon evidence of objective functional improvement. Therefore, the request for authorization of 18 sessions of acupuncture is not medically necessary.

**Chiropractic treatment for the lumbar spine and left knee three times a week for six weeks: 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 Page(s): 58-60.

**Decision rationale:** As per CA MTUS guidelines, manual therapy & manipulation are recommended for chronic pain if caused by musculoskeletal conditions. A trial of 6 visits over 2 weeks is recommended for the low back and with evidence of objective functional improvement a total of up to 18 visits over 6-8 weeks can be approved. Manual therapy and manipulation of the knee are not recommended. There is no indication that the injured worker

had received previous chiropractic therapy so the request is considered as an initial trial. As per MTUS guidelines a trial of 6 visits can be approved with further visits contingent upon evidence of objective functional improvement. The request for 18 visits without evidence of an initial trial with objective functional improvement is not consistent with MTUS guidelines. In addition, as per MTUS guidelines, treatment of the knee is not recommended. Therefore, criteria for medical necessity have not been met and the request for 18 visits of chiropractic treatment is not medically necessary.

**X-rays of the lumbar spine and left knee: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chapter 13 Knee Complaints Page(s): 303-305 and 341-343.

**Decision rationale:** As per ACOEM guidelines, lumbar spinal x-rays should not be recommended in patients with low back pain in the absence of red flags, even if pain has been present for six weeks. Objective findings that identify specific nerve compromise on neurological examination may warrant imaging in those who don't respond to treatment and for whom surgery is an option but when the neurologic examination is less clear, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. The most recent examination showed no evidence of red flag conditions or evidence of specific nerve root compromise. As per ACOEM, special studies are not needed to evaluate most knee complaints until after a period of conservative care and observation. If the patient is able to walk without a limp and had twisting injury with no effusion these may be factors that support the decision not to proceed with radiograph following knee trauma. Parameters for ordering knee radiographs following trauma are joint effusion within 24 hours of a direct blow or fall and palpable tenderness over the fibular head or patella. There was palpable tenderness documented over the medial and lateral joint line of the left knee with slightly decreased range of motion but there was no evidence of effusion or limp. The physician had noted that the injured worker had received x-rays immediately after the industrial injury, but the results and body areas imaged were not documented. The physician noted that the x-rays were being requested for further evaluation of ongoing low back and left knee pain but there was no documentation of what the physician's specific concerns were. In addition, since the results of the previous x-rays were not discussed or submitted and there is no evidence of red flag conditions there is insufficient documentation to establish the medical necessity of additional imaging studies. Therefore, the request for authorization of x-rays of the lumbar spine and left knee is not medically necessary.

**MRI of the lumbar spine and left knee: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chapter 13 Knee Complaints Page(s): 303-305 and 341-343.

**Decision rationale:** As per ACOEM guidelines, objective findings that identify specific nerve compromise on neurological examination may warrant lumbar imaging in those who don't respond to treatment and for whom surgery is an option but when the neurologic examination is less clear, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. The most recent examination showed no evidence of red flag conditions or evidence of specific nerve root compromise. As per ACOEM, special studies are not needed to evaluate most knee complaints until after a period of conservative care and observation. If the patient is able to walk without a limp and had twisting injury with no effusion these may be factors that support the decision not to proceed with radiograph following knee trauma. Parameters for ordering knee radiographs following trauma are joint effusion within 24 hours of a direct blow or fall and palpable tenderness over the fibular head or patella. There was palpable tenderness documented over the medial and lateral joint line of the left knee with slightly decreased range of motion but there was no evidence of effusion or limp. The physician had noted that the injured worker had received MRI studies immediately after the industrial injury, but the results and body areas imaged were not documented. The physician noted that MRI's of the left knee and low back were being requested for further evaluation of ongoing low back and left knee pain but there was no documentation of what the physician's specific concerns were. In addition, since the results of the previous MRI (s) were not discussed or submitted, and there is no evidence of red flag conditions, there is insufficient documentation to establish the medical necessity of additional imaging studies. Therefore, the request for authorization of MRI of the lumbar spine and left knee is not medically necessary.

**Shockwave therapy:** 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) Neck and Upper Back (Acute & Chronic)/Extracorporeal shock wave therapy (ESWT).

**Decision rationale:** The MTUS/ACOEM did not sufficiently address the use of shockwave treatments for the lumbar spine therefore other guidelines were consulted. Per the ODG, ECSWT is "not recommended for back pain. The available evidence does not support the effectiveness of shock wave for treating back pain. In the absence of such evidence, the clinical use of these forms of treatment is not justified and should be discouraged. A review of the injured workers medical records that are available to me do not reveal extenuating circumstances that would warrant deviating from the guidelines therefore the request for Shockwave treatments is not medically necessary.

**Functional capacity evaluation (FCE):** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 1 Prevention Page(s): s 4-5. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness for Duty / Functional capacity evaluation (FCE).

**Decision rationale:** The MTUS states that to determine fitness for duty, it is often necessary to "medically" gauge the capacity of the individual compared with the objective physical requirements of the job based on the safety and performance needs of the employer and expressed as essential functions. Per the ODG, 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. A review of the injured workers medical records that are available to me do not describe a purpose or goal for the evaluation and without this it is difficult to establish medical necessity based on the guidelines. Therefore the request for functional capacity evaluation is not medically necessary at this time.

**EMG/NCV of the bilateral lower extremities:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) chapter, Electrodiagnostic Studies.

**Decision rationale:** As per ACOEM guidelines, electromyography (EMG) may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three to four weeks. As per ODG, EMG is recommended as an option (needle, not surface) to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. Nerve conduction study (NCS) is not recommended. The documentation submitted shows that imaging studies were performed immediately after the industrial injury but these results were not discussed or included. In addition, ODG does not recommend NCS for low back conditions. Given the lack of information regarding the previous imaging studies and that NCS for low back conditions is not recommended, the medical necessity of the testing is not established. Therefore, the request for EMG-NCV of the bilateral lower extremities is not medically necessary.

**Deprizine:** 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 Up to Date.

**Decision rationale:** Deprizine (Ranitidine) oral suspension is a histamine blocker and antacid used to treat peptic ulcers, gastritis and gastro-esophageal reflux (GERD). Ranitidine works by blocking the effects of histamine on the receptor site known as H2. Proton Pump Inhibitors (PPI's) are prescribed to prevent and treat ulcers in the duodenum (where most ulcers develop) and the stomach. Deprizine oral suspension is a suspension consisting of undissolved particles of one or more medicinal agents mixed with a liquid vehicle for oral administration. Evidence-based guidelines and peer-reviewed medical literature do not address the use of medications in oral suspension form. Oral suspensions of medications are generally for use in patients for whom taking the pill/tablet form of the medication is either impractical or unsafe. In this case, there is no documentation in the medical records of any conditions that would preclude the use of medications in their pill/tablet form. In addition, there is no documentation of abnormal subjective or objective gastrointestinal examination findings. In addition, there was no dosage, frequency, quantity or instructions for use provided. Medical necessity of the Deprizine (Ranitidine) oral suspension has not been established. The requested medication is not medically necessary.

**Dicopanol:** 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 Up to Date.

**Decision rationale:** Dicopanol, the oral suspension form of Diphenhydramine, is an antihistamine that is used for the temporary relief of seasonal and perennial allergy symptoms. The medication is sedating and has been used for short-term treatment of insomnia. There is no documentation indicating the patient has any history of insomnia. Dicopanol is generally for use in patients for whom taking the pill/tablet form of the medication is either impractical or unsafe. In this case, there was no documentation in the medical records of any conditions that would preclude the use of medications in their pill/tablet form. In addition, there was no dosage, frequency, quantity or instructions for use provided. Medical necessity for the requested oral suspension medication was not established. The requested medication was not medically necessary.

**Fanatrex:** 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 Anti-Epilepsy Drugs Page(s): 16-22. Decision based on Non-MTUS Citation Up To Date.

**Decision rationale:** According to the CA MTUS guidelines, Fanatrex oral suspension (Gabapentin) is an anti-epilepsy drug, which has been considered a first-line treatment for neuropathic pain. Oral suspensions of medications are generally for use in patients for whom taking the pill/tablet form of the medication is either impractical or unsafe. An oral suspension is a suspension consisting of undissolved particles of one or more medicinal agents mixed with a liquid vehicle for oral administration. Evidence-based guidelines and peer-reviewed medical literature do not address the use of medications in oral suspension form. In this case, there is no documentation in the medical records of any conditions that would preclude the use of medications in their pill/tablet form. In addition, there was no dosage, frequency, quantity or instructions for use provided. Medical necessity for the requested medication, Fanatrex has not been established. The requested medication is not medically necessary.