

Case Number:	CM15-0133551		
Date Assigned:	07/27/2015	Date of Injury:	09/20/2014
Decision Date:	10/08/2015	UR Denial Date:	06/10/2015
Priority:	Standard	Application Received:	07/10/2015

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: 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 38 year old female, who sustained an industrial injury on 9/20/14. Initial complaints were of cumulative type trauma. The injured worker was diagnosed as having headaches; cervical spine sprain/strain; bilateral wrist sprain/strain; thoracic spine pain; thoracic spine sprain/strain; gastroesophageal reflux disease (GERD); low back pain; lumbar spine sprain/strain; bilateral knee sprain/strain; bilateral ankle sprain/strain; anxiety disorder; mood disorder; sleep disorder; stress. Treatment to date has included chiropractic therapy; intense neurostimulation therapy (4/24/15); medications. Diagnostics studies included MRI left and right knee (12/3/14); MRI left and right wrist (12/3/14); MRI cervical spine with flexion-extension (12/1/14); MRI lumbar spine 12/1/14); trigger point's impedance imaging (4/24/15). Currently, the PR-2 notes dated 5/1/15 indicated the injured worker is in the office for a follow-up examination. She reports complaints of sharp, throbbing headache localized at the base of the skull and the temporal region. She describes her pain as frequent and constant, moderate to severe. She rates her pain as 6/10. She complains of sharp, burning, neck pain and muscle spasms. Her pain is described as constant, moderate to severe rating it as 7/10. The pain is aggravated by looking up and down and side-to-side as well as by repetitive motion of the head and neck. It is associated with numbness and tingling of the bilateral upper extremities. She complains of sharp, stabbing, bilateral wrist pain and muscle spasms. Her pain is described as frequent to constant, moderate to severe. The rates her right wrist pain as 6/10 and the left as 5-6/10. The pain is aggravated by gripping, grasping, reaching, pulling and lifting. She also complains of weakness, numbness, tingling and pain radiating to the hands and fingers. She

complains of burning pain in her chest right after having a meal. She complains of sharp, stabbing mid back pain and muscle spasms. She rates her pain as 5/10 and aggravated by prolonged positioning including sitting, standing, walking and bending. She complains of sharp, stabbing low back pain and muscle spasms. She rates the pain at the low back as 7/10 and describes it as frequent to constant, moderate to severe. It is associated with numbness and tingling of the bilateral lower extremities. It is aggravated by sitting, standing, walking, bending, and arising from the sitting position, ascending and descending stairs and stooping. She complains of bilateral knee pain as sharp, stabbing and muscle spasms. The right knee pain is rated at 7-8/10 and left as 6/10. It is described as constant, moderate to severe and aggravated by squatting, kneeling, ascending or descending stairs, prolonged positioning including weight bearing, standing, and walking. She also complains of numbness, tingling and pain radiating to the feet. She complains of dull, achy bilateral ankle pain and muscle spasms. She rates the right ankle pain as 4/10 and left as 4/10. It is described as constant, moderate to severe and aggravated by squatting, kneeling, ascending or descending stairs, prolonged positioning including weight bearing. All areas mentioned showed tenderness to palpation over the spinous process, muscles and joints with decreased range of motion and muscle guarding. The provider is requesting authorization of Terocin patches; Acupuncture 3x6 weeks to the cervical spine, bilateral wrists, thoracic spine, lumbar spine, bilateral knees and bilateral ankles; Chiropractic 3x6 weeks to the cervical spine, bilateral wrists, thoracic spine, lumbar spine, bilateral knees and bilateral ankles; Physical therapy 3x6 weeks to the cervical spine, bilateral wrists, thoracic spine, lumbar spine, bilateral knees and bilateral ankles; Intense neurostimulation therapy (LINT) x6 sessions to the lumbar; Shockwave therapy, up to 3 treatments for the right and left wrist; Shockwave therapy, up to 3 treatments for the right and left knee; Shockwave therapy, up to 3 treatments for the right and left ankle; Shockwave therapy, up to 6 treatments for the cervical spine; Shockwave therapy, up to 6 treatments for the thoracic and lumbar spine; MRI of the thoracic and right and left ankle and EMG/NCV study of the bilateral upper and lower extremities.

IMR ISSUES, DECISIONS AND RATIONALES

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

Terocin patches: 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): Lidoderm (lidocaine patch).

Decision rationale: According to the MTUS, compounds containing lidocaine are not recommended for non-neuropathic pain. There is only one trial that tested 4% lidocaine for treatment of chronic muscle pain. The results showed there was no superiority over placebo. The patient's physical exam shows no evidence of radiculopathy or neuropathic pain. In addition, there is little to no research to support the use of many of these Compounded Topical Analgesics. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Terocin patches are not medically necessary.

Acupuncture 3x6 weeks to the cervical spine, bilateral wrists, thoracic spine, lumbar spine, bilateral knees and bilateral ankles: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment 2007.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment 2007.

Decision rationale: The Acupuncture Medical Treatment Guidelines allow acupuncture treatments to be extended if functional improvement is documented as defined in Section 9792.20(f). The initial authorization for acupuncture is for 3-6 treatments. Authorization for more than 6 treatments would be predicated upon documentation of functional improvement. There is no documentation in the medical record that the patient has had functional improvement with the trial of visits of acupuncture previously authorized. Acupuncture 3x6 weeks to the cervical spine, bilateral wrists, thoracic spine, lumbar spine, bilateral knees and bilateral ankles is not medically necessary.

Chiropractic 3x6 weeks to the cervical spine, bilateral wrists, thoracic spine, lumbar spine, bilateral knees and bilateral ankles: 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): Manual therapy & manipulation.

Decision rationale: The request is for 18 visits of chiropractic. The Chronic Pain Medical Treatment Guidelines allow for an initial 4-6 visits after which time there should be documented functional improvement prior to authorizing more visits. The request for 18 chiropractic visits is more than what is medically necessary to establish whether the treatment is effective. This patient has already attended chiropractic therapy, but no functional improvement was documented in the medical records supplied for review. Chiropractic 3x6 weeks to the cervical spine, bilateral wrists, thoracic spine, lumbar spine, bilateral knees and bilateral ankles is not medically necessary.

Physical therapy 3x6 weeks to the cervical spine, bilateral wrists, thoracic spine, lumbar spine, bilateral knees and bilateral ankles: 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): Manual therapy & manipulation.

Decision rationale: The MTUS allows for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Prior to full authorization, therapeutic physical therapy is authorized for trial of 6 visits over 2 weeks, with evidence of

objective functional improvement prior to authorizing more treatments. There is no documentation of objective functional improvement and the request is for greater than the number of visits necessary for a trial to show evidence of objective functional improvement prior to authorizing more treatments. Physical therapy 3x6 weeks to the cervical spine, bilateral wrists, thoracic spine, lumbar spine, bilateral knees and bilateral ankles is not medically necessary.

Intense neurostimulation therapy (LINT) x6 sessions to the lumbar: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Percutaneous electrical nerve stimulation (PENS).

Decision rationale: Localized Intense Neurostimulation Therapy (LINT) is equivalent to Percutaneous Electrical Nerve Stimulation (PENS). The Official Disability Guidelines do not recommend percutaneous electrical nerve stimulation has a primary treatment modality. There is a lack of high quality evidence to prove long-term efficacy. A trial may be considered, if used as an adjunct to a program of evidence-based functional restoration, after other non-surgical treatments, including therapeutic exercise and TENS, have been tried and failed or are judged to be unsuitable or contraindicated. Intense neurostimulation therapy (LINT) x6 sessions to the lumbar is not medically necessary.

Shockwave therapy, up to 3 treatments for the right and left wrist: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Elbow-online version, Extracorporeal shockwave therapy (ESWT).

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 (Acute & Chronic), Extracorporeal shock wave therapy (ESWT).

Decision rationale: Limited evidence exists regarding extracorporeal shock wave therapy (ESWT) in reducing pain and improving function. While it appears to be safe, there is disagreement as to its efficacy. Insufficient high quality scientific evidence exists to determine clearly the effectiveness of this therapy. Shockwave therapy, up to 3 treatments for the right and left wrist is not medically necessary.

Shockwave therapy, up to 3 treatments for the right and left knee: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Knee & Leg-online version, Extracorporeal shock wave therapy.

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

Decision rationale: Limited evidence exists regarding extracorporeal shock wave therapy (ESWT) in reducing pain and improving function. While it appears to be safe, there is disagreement as to its efficacy. Insufficient high quality scientific evidence exists to determine clearly the effectiveness of this therapy. Shockwave therapy, up to 3 treatments for the right and left knee is not medically necessary.

Shockwave therapy, up to 3 treatments for the right and left ankle: Upheld

Claims Administrator guideline: Decision based on MTUS Ankle and Foot 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) Ankle & Foot (Acute & Chronic), Extracorporeal shock wave therapy (ESWT).

Decision rationale: Limited evidence exists regarding extracorporeal shock wave therapy (ESWT) in reducing pain and improving function. While it appears to be safe, there is disagreement as to its efficacy. Insufficient high quality scientific evidence exists to determine clearly the effectiveness of this therapy. Shockwave therapy, up to 3 treatments for the right and left ankle is not medically necessary.

Shockwave therapy, up to six treatments to the cervical spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. CharFormat Decision based on Non-MTUS Citation www.ncbi.nlm.nih.gov- Extracorporeal shockwave therapy in musculoskeletal disorders..

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: Limited evidence exists regarding extracorporeal shock wave therapy (ESWT) in reducing pain and improving function. While it appears to be safe, there is disagreement as to its efficacy. Insufficient high quality scientific evidence exists to determine clearly the effectiveness of this therapy. Shockwave therapy, up to six treatments to the cervical spine is not medically necessary.

Shockwave therapy, up to six treatments to the thoracic and lumbar spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back-online version, Shockwave therapy.

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), Extracorporeal shock wave therapy (ESWT).

Decision rationale: Limited evidence exists regarding extracorporeal shock wave therapy (ESWT) in reducing pain and improving function. While it appears to be safe, there is disagreement as to its efficacy. Insufficient high quality scientific evidence exists to determine clearly the effectiveness of this therapy. Shockwave therapy, up to six treatments to the thoracic and lumbar spine is not medically necessary.

MRI of the thoracic spine and right and left ankle: Upheld

Claims Administrator guideline: Decision based on MTUS Ankle and Foot Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Ankle and Foot Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), MRIs (magnetic resonance imaging).

Decision rationale: The Official Disability Guidelines state that indications for a thoracic MRI include trauma, thoracic pain suspicious for cancer or infection, cauda equina syndrome, or myelopathy. The exam indicates that the patient has complaining of mid back pain without evidence of long track signs, bowel or bladder dysfunction, or progressive neurologic deficit. There is no documentation of any of the above criteria supporting a recommendation of a thoracic MRI. Routine testing, i.e., laboratory tests, plain-film radiographs of the foot or ankle, and special imaging studies are not recommended during the first month of activity limitation, except when a red flag noted on history or examination raises suspicion of a dangerous foot or ankle condition or of referred pain. In particular, patients who have suffered ankle injuries caused by a mechanism that could result in fracture can have radiographs if the Ottawa Criteria are met. This patient does not have any red-flag indicators or new injuries. MRI of the thoracic spine and right and left ankle is not medically necessary.

EMG/NCV study of the bilateral upper and lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, and Low Back Complaints 2004. Decision based on Non-MTUS Citation ODG Low Back-online version, Nerve conduction studies (NCS).

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), Electromyography (EMG).

Decision rationale: The Official Disability Guidelines do not recommended repeat electrodiagnostic studies to demonstrate radiculopathy if radiculopathy has already been clearly identified by EMG and obvious clinical signs, but recommended if the EMG is not clearly radiculopathy or clearly negative, or to differentiate radiculopathy from other neuropathies or non-neuropathic processes if other diagnoses may be likely based on the clinical exam. There is

minimal justification for performing nerve conduction studies when a patient is already presumed to have symptoms on the basis of radiculopathy. EMG/NCV study of the bilateral upper and lower extremities is not medically necessary.

Referral to a neurologist: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Occupational Medicine Practice Guidelines, 2nd edition, 2004, page 127.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine Occupational Medicine Practice Guidelines, 2nd Edition Chapter 7, Independent Medical Examinations and Consultations, Page 132.

Decision rationale: According to the MTUS, a referral request should specify the concerns to be addressed in the independent or expert assessment, including the relevant medical and non-medical issues, diagnosis, causal relationship, prognosis, temporary or permanent impairment, workability, clinical management, and treatment options. The medical record lacks sufficient documentation and does not support a referral request. Referral to a neurologist is not medically necessary.