

Case Number:	CM15-0181865		
Date Assigned:	09/30/2015	Date of Injury:	02/18/2015
Decision Date:	12/01/2015	UR Denial Date:	08/21/2015
Priority:	Standard	Application Received:	09/15/2015

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: New York

Certification(s)/Specialty: Internal 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 62 year old male, who sustained an industrial injury on 2-18-2015. Medical records indicate the worker is undergoing treatment for lumbosacral sprain-strain, right hip osteoarthritis and right knee sprain-strain. A recent progress report dated 8-3-2015, reported the injured worker complained of right sided lumbar pain rated 6 out of 10 with radiation to the right lower extremity, right hip pain rated 7 out of 10 and right knee pain rated 6 out of 10. Physical examination revealed lumbar paravertebral tenderness and sacroiliac tenderness, right hip pain with flexion and extension and right knee tenderness and crepitation. Treatment to date has included physical therapy and medication management. Lumbar x ray showed diffuse idiopathic skeletal hyperostosis-thoracic spine, lumbar discogenic spondylosis, joint arthrosis and osteopenia. Right hip X-ray showed displaced fracture of the greater trochanter, hip-joint osteoarthritis and osteopenia. Right knee X-ray showed patello-femoral and femoro-tibial joint osteoarthritis and osteopenia. The physician is requesting chiropractic care for 12 visits, lumbar X-ray, Fluri-Menthol-Caps-Camph, TENS/EMs neurostimulator for one month home based trial with supplies, baseline functional capacity evaluation, right knee hinged brace, retrospective left hip X-ray and retrospective right knee x ray. On 8-21-2015, the Utilization Review noncertified the request for chiropractic care for 12 visits, lumbar X-ray, Fluri-Menthol-Caps-Camph, TENS/EMs neurostimulator for one month home based trial with supplies, baseline functional capacity evaluation, right knee hinged brace, retrospective left hip X-ray and retrospective right knee X-ray.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic 3 times a week for 4 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004, and Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter.

Decision rationale: MTUS recommends a trial of 6 Chiropractic visits over 2 weeks for initial treatment of low back pain. With evidence of objective functional improvement, a total of up to 18 visits over 6-8 weeks may be prescribed. Per MTUS, elective/maintenance care is not medically necessary. Documentation shows that the injured worker complains of ongoing low back pain with no report of significant improvement in physical function with previous physical therapy. Although there may be benefit from chiropractic treatment, the requested number of visits exceeds that recommended for initial trial. The request for Chiropractic 3 times a week for 4 weeks is not medically necessary.

X-ray lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

Decision rationale: MTUS recommends Lumbar spine X-rays in patients with low back pain only when there is evidence of red flags for serious spinal pathology, even if the pain has persisted for at least six weeks. Imaging in patients who do not respond to treatment may be warranted if there are objective findings that identify specific nerve compromise on the neurologic examination and if surgery is being considered as an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Documentation shows that the injured worker has had prior X-rays and there is lack of objective clinical evidence of specific nerve compromise on the neurologic examination or acute exacerbation of symptoms to support the medical necessity for repeat X-rays. The request for X-ray lumbar spine is not medically necessary.

Fluri-Menthol-Caps-Camph: 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: MTUS states that use of topical analgesics is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many of these agents. Flurbiprofen is not FDA approved for topical application and MTUS provides no evidence recommending the use of topical Menthol or Camphor. Per guidelines, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The request for Fluri-Menthol-Caps-Camph is not medically necessary.

TENS/EMs neurostimulator for one month home based trial with supplies: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004, and Chronic Pain Medical Treatment 2009.

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

Decision rationale: MTUS guidelines state that a TENS unit may be recommended in the treatment of chronic intractable pain conditions, if there is documentation of pain for at least three months duration, evidence that other appropriate pain modalities including medications have been tried and failed and that a one-month trial period of the TENS unit has been prescribed, as an adjunct to ongoing treatment modalities within a functional restoration program. There should be documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; rental would be preferred over purchase during this trial. A treatment plan including the specific short- and long-term goals of treatment with the TENS unit should also be submitted. Physician report at the time of the requested service fails to indicate a specific functional restoration program is being prescribed and there is lack of documentation regarding short- and long-term treatment goals. The request for TENS/EMs neurostimulator for one-month home based trial with supplies is not medically necessary.

Baseline functional capacity evaluation: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Fitness for Duty Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Functional restoration programs (FRPs). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Programs.

Decision rationale: Per guidelines, Functional Restorative Programs were designed to use a medically directed, interdisciplinary pain management approach geared specifically to patients with chronic disabling occupational musculoskeletal disorders. They are recommended for patients with conditions that have resulted in delayed recovery. Per guidelines, Functional

Restorative Programs were designed to use a medically directed, interdisciplinary pain management approach geared specifically to patients with chronic disabling occupational musculoskeletal disorders. They are recommended for patients with conditions that have resulted in delayed recovery. Chart documentation indicates that the injured worker is undergoing active treatment for ongoing low back, right hip and knee pain. Not having reached maximum medical therapy at the time of the request under review, guidelines have not been met. The request for Baseline functional capacity evaluation is not medically necessary.

Right knee hinged brace: 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), Knee Chapter.

MAXIMUS guideline: Decision based on MTUS Knee Complaints 2004, Section(s): Initial Care. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee Chapter, Knee brace.

Decision rationale: Per guidelines, knee braces may be used in treating patients with conditions including Knee instability, ligament insufficiency/deficiency, reconstructed ligament, painful failed total knee arthroplasty and painful unicompartmental osteoarthritis. MTUS goes on to state that braces need to be used in conjunction with a rehabilitation program and that the benefits be more emotional (i.e., increasing the patient's confidence) than medical. The injured worker complains of right knee pain. Physical examination findings do not show severe instability of the knee to warrant the use of a knee brace. The request for Right knee hinged brace is not medically necessary.

Retrospective X-Ray left hip: 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), Hip and Pelvis Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip Replacement Chapter, X-ray.

Decision rationale: MTUS does not address this request. ODG recommends plain radiographs (X-Rays) of the pelvis in patients sustaining a severe injury in identifying patients with a high risk of the development of hip osteoarthritis. The injured worker complains of chronic hip pain. Documentation fails to show objective evidence indicating a significant change in symptoms or clinical findings to establish the medical necessity for plain X-rays. The request for Retrospective X-Ray left hip is not medically necessary.

Retrospective X-ray right knee: 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), Hip and Pelvis Chapter.

MAXIMUS guideline: Decision based on MTUS Knee Complaints 2004, Section(s): Special Studies.

Decision rationale: MTUS recommends plain-film radiographs of the knee, and special imaging studies only after a period of conservative care and observation, and only when a red flag is noted on history or examination such as significant hemarthrosis or the inability to flex the knee to 90 degrees, raising suspicion of conditions including fracture. Documentation fails to show any red flags on physical examination to support the medical necessity of a knee X-ray. The request for Retrospective X-ray right knee is not medically necessary.