MAXIMUS Federal Services

Case Number:	CM15-0184419		
Date Assigned:	10/01/2015	Date of Injury:	08/02/2014
Decision Date:	12/09/2015	UR Denial Date:	08/26/2015
Priority:	Standard	Application Received:	09/18/2015

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: Tennessee, Florida, Ohio
Certification(s)/Specialty: Surgery, Surgical Critical Care

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 35 year old female, who sustained an industrial injury on 8-2-2014. Medical records indicate the worker is undergoing treatment for low back pain, lumbar disc displacement0hnp, lumbar degenerative disc disease, bilateral lower extremities radiculitis, bilateral knee pain, bilateral knee medial and lateral meniscus tear, bilateral knee tendinitis, bilateral knee patella chondromalacia and right ankle sprain-strain. A recent progress report dated 8-10-2015, reported the injured worker complained of sharp stabbing low back pain rated 6 out of 10 associated with numbness and tingling of the bilateral lower extremities, bilateral knee pain rated 4-6 out of 10 and right ankle pain and muscle spasm rated 6 out of 10. Physical examination revealed lumbar paraspinal guarding, lumbar 3-5 tender spinous processes, positive straight leg raise test bilaterally and lumbar range of motion of: flexion 15 degrees, extension 15 degrees, left lateral flexion 10 degrees, right lateral flexion 15 degrees and bilateral rotation of 15 degrees. Bilateral knee examination showed tenderness to palpation of the medial and lateral joint line and the patello-femoral joint with bilateral flexion of 85 degrees and extension of -10 degrees. The right ankle was tender at the medial and lateral malleolus with range of motion within normal limits. Treatment to date has included physical therapy and medication management. The physician requested lumbar x ray, TENS (transcutaneous electrical nerve stimulation) unit with supplies, hot-cold unit, 18 sessions of physical therapy for the lumbar spine, 18 sessions of acupuncture for the lumbar spine, 6 sessions of shockwave therapy, 6 sessions of localized intense Neurostimulation and unknown prescriptions of: Terocin patches, Tabradol, Synapryn, Fanatrex, Deprizine, Dicopanol, Cyclobenzaprine and Ketoprofen

cream. On 8-25-2015, the Utilization Review noncertified the request for lumbar x ray, TENS (transcutaneous electrical nerve stimulation) unit with supplies, hot-cold unit, 6 sessions of shockwave therapy, 6 sessions of localized intense Neurostimulation and unknown prescriptions of: Terocin patches, Tabradol, Synapryn, Fanatrex, Deprizine, Dicopanol, Cyclobenzaprine and Ketoprofen cream. The Utilization Review modified the request for 18 sessions of physical therapy for the lumbar spine to 6 sessions and 18 sessions of acupuncture for the lumbar spine to 3 sessions.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 X-ray of lumbar spine: Upheld

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

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

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this request for this patient. X-ray of the lumbar spine is not medically necessary per the MTUS ACOEM Guidelines. The MTUS guidelines state that lumbar spine x-rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least six weeks. The medical documentation supports that this patient does not have any red flag symptomatology. He has had chronic pain for more than a year with prior imaging. Per MTUS, an x-ray for the lumbar spine is not indicated. Therefore, based on the submitted medical documentation, the request for lumbar spine x-ray is not medically necessary.

1 TENS unit with supplies: 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 rationale: There is not sufficient clinical information provided to justify the medical necessity of a TENS unit for this patient. The California MTUS guidelines recommend the following regarding criteria for TENS unit use: 1.Chronic intractable pain (for the conditions noted above): Documentation of pain of at least three months duration. 2. There is evidence that other appropriate pain modalities have been tried (including medication) and failed; A one-month trial period of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with 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 trial3. Other ongoing pain treatment should also be documented during the trial period including medication usage. 4. A treatment plan including the specific short- and

long-term goals of treatment with the TENS unit should be submitted. 5. A 2-lead unit is generally recommended; if a 4-lead unit is recommended, there must be documentation of why this is necessary. This patient's case does not meet the recommended criteria since no treatment plan (that includes short and long term goals) was submitted. Therefore, based on the submitted medical documentation, the request for TENs unit is not-medically necessary.

1 Hot/Cold unit: 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) Back Pain, (Acute and Chronic), functional therapies.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this request for this patient. The MTUS Chronic Pain Guidelines do not address the topic of shockwave therapy. ACOEM Guidelines state, "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." The Official Disability Guidelines note that hot cold therapy is not recommended for patients whose pain has remained despite standard treatment. Within the provided documentation, the requesting physician did not include an adequate and complete assessment of the patient's current objective functional condition in order to demonstrate functional deficits needing to be addressed with the treatments. Therefore, based on the submitted medical documentation, the request for hot cold therapy is not medically necessary.

18 Sessions of physical therapy for the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Physical therapy.

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

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of physical therapy for this patient. The value of physical therapy increases when a physician gives the therapist a specific diagnosis of the lesion causing the patient's symptoms. With a prescription that clearly states treatment goals, a physician can use communication with the therapist to monitor such variables as motivation and compliance. The California MTUS Guidelines state that physician should allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. In a large case series of patients with low back pain treated by physical therapists, those adhering to guidelines

for active rather than passive treatments incurred fewer treatment visits, cost less, and had less pain and less disability. Physical therapy is recommended by MTUS as follows: Myalgia and myositis, unspecified: 9-10 visits over 8 weeks; Neuralgia, neuritis, and radiculitis, unspecified: 8-10 visits over 4 weeks; Reflex sympathetic dystrophy: 24 visits over 16 weeks. The medical records support that this patient has lumbar back pain; however, the requested PT sessions are not indicated because they exceed MTUS recommendations for therapy. Documentation of the success of prior PT sessions with functional restoration or improvement is not provided. Therefore, based on the submitted medical documentation, the request for physical therapy is not medically necessary.

18 Sessions of acupuncture for the lumbar spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment 2007.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of acupuncture testing for this patient. The California MTUS Acupuncture guidelines address the topic of acupuncture to the back. In accordance with California MTUS Acupuncture guidelines "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." This patient has been prescribed acupuncture for 18 sessions. Based on MTUS guidelines, a trial of acupuncture is clinically appropriate for up to 6 sessions. Since the requested number of sessions greatly exceeds the suggested trial sessions, the therapy is not indicated. Therefore, based on the submitted medical documentation, the request for acupuncture testing is not medically necessary for 18 sessions.

6 Sessions of shockwave therapy for the lumbar spine: 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), Low Back, 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) back pain (acute and chronic), shockwave therapy.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this request for this patient. The MTUS Chronic Pain Guidelines do not address the topic of shockwave therapy. ACOEM Guidelines state, "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." The Official Disability Guidelines note extracorporeal shock wave therapy is recommended for patients whose pain from calcifying

tendinitis of the shoulder has remained despite six months of standard treatment. Within the provided documentation, the Guidelines recommend the use of shockwave treatment for the shoulder; however, there are no indications for use in the lumbar spine. Within the provided documentation, the requesting physician did not include an adequate and complete assessment of the patient's current objective functional condition in order to demonstrate functional deficits needing to be addressed with the treatments. Additionally, the requesting physician's rationale for the request was unclear. Therefore, based on the submitted medical documentation, the request for shockwave therapy is not medically necessary.

6 Sessions of localized intense neurostimulation for the lumbar spine: 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), Low Back-Lumbar and Thoracic (Acute and Chronic), Localized Intense Neuro-stimulation Therapy (Hyperstimulation analgesia).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Percutaneous electrical nerve stimulation (PENS).

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this request for this patient. Based on the description of the modality in question, localized intense neurostimulation therapy appears to represent a form of percutaneous electrical neurostimulation (PENS) therapy. As noted on page 97 of the MTUS Chronic Pain Medical Treatment Guidelines, PENS are not recommended as a primary treatment modality but can be considered on a trial basis if used as an adjunct to a program of evidence based functional restoration, after other nonsurgical options such as therapeutic exercise and TENS have been tried and/or failed. In this case, however, there is no clear evidence that the employee has tried and failed conventional TENS unit. There is no evidence that the employee is intent on functional restoration. Therefore, based on the submitted medical documentation, the request for neurostimulation is not medically necessary.

Unknown prescription of Terocin patches: Upheld

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

MAXIMUS guideline: Decision based on MTUS General Approaches 2004, Section(s): Initial Approaches to Treatment.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this prescription for this patient. The clinical records submitted do not support prescription of a recommended dose or frequency for use of this medication. The California MTUS guidelines address the topic of prescriptions. Per the guidelines, "There will be a limit of number of medications, and dose of specific medications." The requested prescription does not have a quantity, dose or dispensing instructions provided. Therefore, based on the submitted medical documentation, the request for Terocin patches is not medically necessary.

Unknown prescription of Tabradol: Upheld

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

MAXIMUS guideline: Decision based on MTUS General Approaches 2004, Section(s): General Approach to Initial Assessment and Documentation, Initial Approaches to Treatment.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this prescription for this patient. The clinical records submitted do not support prescription of a recommended dose or frequency for use of this medication. The California MTUS guidelines address the topic of prescriptions. Per the guidelines, "There will be a limit of number of medications, and dose of specific medications." The requested prescription does not have a quantity, dose or dispensing instructions provided. Therefore, based on the submitted medical documentation, the request for Tabradol patches is not medically necessary.

Unknown prescription of Synapryn: Upheld

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

MAXIMUS guideline: Decision based on MTUS General Approaches 2004, Section(s): General Approach to Initial Assessment and Documentation, Initial Approaches to Treatment.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this prescription for this patient. The clinical records submitted do not support prescription of a recommended dose or frequency for use of this medication. The California MTUS guidelines address the topic of prescriptions. Per the guidelines, "There will be a limit of number of medications, and dose of specific medications." The requested prescription does not have a quantity, dose or dispensing instructions provided. Therefore, based on the submitted medical documentation, the request for Synapryn is not medically necessary.

Unknown prescription of Fanatrex: Upheld

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

MAXIMUS guideline: Decision based on MTUS General Approaches 2004, Section(s): General Approach to Initial Assessment and Documentation, Initial Approaches to Treatment.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this prescription for this patient. The clinical records submitted do not support prescription of a recommended dose or frequency for use of this medication. The California MTUS guidelines address the topic of prescriptions. Per the guidelines, "There will be a limit of number of medications, and dose of specific medications."The requested prescription does not have a quantity, dose or dispensing instructions provided. Therefore, based on the submitted medical documentation, the request for Fanatrex is not medically necessary.

Unknown prescription of Deprizine: Upheld

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

MAXIMUS guideline: Decision based on MTUS General Approaches 2004, Section(s): Initial Approaches to Treatment, General Approach to Initial Assessment and Documentation.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this prescription for this patient. The clinical records submitted do not support prescription of a recommended dose or frequency for use of this medication. The California MTUS guidelines address the topic of prescriptions. Per the guidelines, "There will be a limit of number of medications, and dose of specific medications." The requested prescription does not have a quantity, dose or dispensing instructions provided. Therefore, based on the submitted medical documentation, the request for Deprizine is not medically necessary.

Unknown prescription of Dicopanol: Upheld

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

MAXIMUS guideline: Decision based on MTUS General Approaches 2004, Section(s): General Approach to Initial Assessment and Documentation, Initial Approaches to Treatment.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this prescription for this patient. The clinical records submitted do not support prescription of a recommended dose or frequency for use of this medication. The California MTUS guidelines address the topic of prescriptions. Per the guidelines, "There will be a limit of number of medications, and dose of specific medications." The requested prescription does not have a quantity, dose or dispensing instructions provided. Therefore, based on the submitted medical documentation, the request for Dicopanol is not medically necessary.

Unknown prescription of Cyclobenzaprine: Upheld

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

MAXIMUS guideline: Decision based on MTUS General Approaches 2004, Section(s): General Approach to Initial Assessment and Documentation, Initial Approaches to Treatment.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this prescription for this patient. The clinical records submitted do not support prescription of a recommended dose or frequency for use of this medication. The California MTUS guidelines address the topic of prescriptions. Per the guidelines, "There will be a limit of number of medications, and dose of specific medications." The requested prescription does not have a quantity, dose or dispensing instructions provided. Therefore, based on the submitted medical documentation, the request for Cyclobenzaprine is not medically necessary.

Unknown prescription of Ketoprofen cream: Upheld

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

MAXIMUS guideline: Decision based on MTUS General Approaches 2004, Section(s): General Approach to Initial Assessment and Documentation, Initial Approaches to Treatment.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this prescription for this patient. The clinical records submitted do not support prescription of a recommended dose or frequency for use of this medication. The California MTUS guidelines address the topic of prescriptions. Per the guidelines, "There will be a limit of number of medications, and dose of specific medications." The requested prescription does not have a quantity, dose or dispensing instructions provided. Therefore, based on the submitted medical documentation, the request for Ketoprofen is not medically necessary.