

Case Number:	CM15-0027089		
Date Assigned:	02/19/2015	Date of Injury:	03/05/2014
Decision Date:	05/20/2015	UR Denial Date:	02/12/2015
Priority:	Standard	Application Received:	02/12/2015

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, Public Health & General Preventive 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:

This 42 year old female sustained an industrial injury on 3/5/14. The patient had undergone electrodiagnostic testing on 5/26/2014 and a functional capacity evaluation on 6/28/2014. In a first report of occupational injury dated 5/20/14, the injured worker complained of neck pain 9/10 on the visual analog scale, low back pain 7/10 and left shoulder pain. A physical examination showed pain on range of motion with range of motion of the lumbar spine at flexion of 60 degrees, extension at 0 degrees, right and left lateral bending at 20 degrees, and right and left flexion at 25 degrees. There was pain with range of motion of the left shoulder with range of motion at 175 degrees with flexion, 45 degrees with extension, 50 degrees with abduction and adduction, internal rotation at 45 degrees, and external rotation at 90 degrees. The left knee showed flexion of 140 degrees and extension of 0 degrees. The injured worker was diagnosed with left shoulder, lumbar and cervical strain/sprain. The treatment plan included magnetic resonance imaging lumbar spine and cervical spine, electromyography/nerve conduction velocity test left shoulder, return to work in two days, physical therapy twice a week for six weeks, acupuncture twice a week for six weeks, inferential stimulator and topical compound creams. On 2/12/15, Utilization Review noncertified a request for Interferential stimulator (IF unit) plus supplies for period of medical necessity, 12 months, Acupuncture treatment; 12 sessions 2x6, for the lumbar spine, Functional capacity evaluation, Voltage actuated sensory nerve conduction, electromyography/nerve conduction velocity test, Gabapentin 10%, Lidocaine 5%, Tramadol 15% 210 gm and Cyclobenzaprine 2% Tramadol 10% Flurbiprofen 20% 210gm. Utilization Review

modified a request for Physiotherapy; 12 sessions 2x6 for the lumbar spine to six sessions. Utilization Review cited ODG and CA MTUS Chronic Pain Medical Treatment Guidelines. As a result of the UR denial, an IMR was filed with the Division of Workers Comp.

IMR ISSUES, DECISIONS AND RATIONALES

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

Interferential stimulator (IF unit) plus supplies for period of medical necessity, 12 months:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy, Interferential Current Stimulation (ICS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118.

Decision rationale: California MTUS Guidelines do not recommend Neuromuscular electrical stimulation (NMES devices) as there is no evidence to support its use in chronic pain. They do not recommend Interferential Current Stimulation (ICS) as an isolated intervention and galvanic stimulation is considered investigational for all indications. It is characterized by high voltage, pulsed stimulation and is used primarily for local edema reduction through muscle pumping and polarity effect and is not recommended. No recent clinical information was provided to support the medical necessity of an IF stimulator unit, plus supplies for 12 months. There is no indication that the injured worker would be using this as an adjunct to other treatment modalities with a functional restoration approach. There is also no indication that he has undergone a 30 day trial with success. Therefore, the request is not supported. As such, the request is not medically necessary.

Acupuncture treatment; 12 sessions 2x6, for the lumbar spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: California MTUS guidelines state that acupuncture is used as an option when pain medication is reduced or not tolerated and it is recommended as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Acupuncture can be used to reduce pain, reduce inflammation, increase blood flow, increase range of motion, decrease the side effect of medication-induced nausea, promote relaxation in an anxious patient, and reduce muscle spasm. The time to produce functional improvement is 3 - 6 treatments and Acupuncture treatments may be extended if functional improvement is documented including either a clinically significant improvement in activities of daily living or a reduction in work restrictions. No recent clinical documentation was submitted regarding the injured worker's condition to show that he has significant deficits in the lumbar spine that would support the medical necessity of acupuncture treatment. Also, 12 sessions for the lumbar spine would

exceed the guidelines as it is stated that 3 to 6 treatments are adequate to produce an improvement in function. Therefore, the request is not supported. As such, the request is not medically necessary.

Functional capacity evaluation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines 2nd Ed., Independent Medical Examinations and Consultations Chapter.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92.

Decision rationale: ACOEM guidelines indicate there is a functional assessment tool available and that is a Functional Capacity Evaluation, however, it does not address the criteria. As such, secondary guidelines were sought. Official Disability Guidelines indicates that a Functional Capacity Evaluation is appropriate when a worker has had prior unsuccessful attempts to return to work, has conflicting medical reports, the patient had an injury that required a detailed exploration of a workers abilities, a worker is close to maximum medical improvement and/or additional or secondary conditions have been clarified. However, the evaluation should not be performed if the main purpose is to determine a worker's effort or compliance or the worker has returned to work and an ergonomic assessment has not been arranged. It is recommended prior to admission to a Work Hardening (WH) Program, with preference for assessments tailored to a specific task or job. Recommended prior to admission to a Work Hardening (WH) Program, with preference for assessments tailored to a specific task or job. It was noted within the clinical documentation that the injured worker has already undergone a Functional Capacity Evaluation. A clear rationale was not supported for the medical necessity of an additional Functional Capacity Evaluation. There was no indication that the injured worker was entering into a work hardening program or that he had any of the indications that would support the request for a Functional Capacity Evaluation. Therefore, the request is not supported. As such, the request is not medically necessary.

Voltage actuated sensory nerve conduction: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Low Back Chapter, Current perception threshold (CPT) testing.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

Decision rationale: The California ACOEM Guidelines indicate that unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in those with persistent symptoms. It is also stated that EMG and nerve conduction studies may be carried out to evaluate lateral arm pain. The documentation provided does not indicate that the injured worker has any significant neurological deficits.

There was also no recent clinical documentation showing the presence of neurological deficits that would support the request. Without this information, the request would not be supported. As such, the request is not medically necessary.

EMG/NCV: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 60-61. Decision based on Non-MTUS Citation ODG for Low Back Chapter, EMGs (electromyography) and nerve conduction studies (NCS) sections.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

Decision rationale: The California ACOEM Guidelines indicate that unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in those with persistent symptoms. It is also stated that EMG and nerve conduction studies may be carried out to evaluate lateral arm pain. The documentation provided does not indicate that the injured worker has any significant neurological deficits. There was also no recent clinical documentation showing the presence of neurological deficits that would support the request. Also, it was noted that the injured worker had already undergone electrodiagnostic studies and a clear rationale was not provided for the medical necessity of additional studies. Without this information, the request would not be supported. As such, the request is not medically necessary.

Physiotherapy; 12 sessions 2x6 for the lumbar spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

Decision rationale: The California MTUS Guidelines indicate that physical therapy is recommended for 9 to 10 visits over 8 weeks for myalgia and myositis unspecified. For neuralgia, neuritis, and radiculitis unspecified, 8 to 10 visits over 4 weeks is recommended. No recent clinical documentation was submitted regarding the injured worker's condition to show that she has the presence of significant functional deficits that would support the request for physical therapy sessions. Also, the number of sessions being requested exceeds the guideline recommendations. Therefore, the request is not supported. As such, the request is not medically necessary.

Gabapentin 10%, Lidocaine 5%, Tramadol 15% 210 gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-114.

Decision rationale: According to the cervical spine MTUS Guidelines, topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Topical gabapentin and cyclobenzaprine, as well as other muscle relaxants are not recommended for topical use as there is a lack of peer reviewed literature to support their use as a topical agent. No recent clinical documentation was submitted regarding the injured worker's condition to show that this medication has been effective in treating his pain and symptoms and therefore, the request would not be supported. There is also no indication that he has failed recommended oral medications. Furthermore, the requested compound cream contains medications that are not supported by the guidelines for topical use. Therefore, the request is not supported. As such, the request is not medically necessary.

Cyclobenzaprine 2% Tramadol 10% Flurbiprofen 20% 210gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-114.

Decision rationale: According to the cervical spine MTUS Guidelines, topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Topical gabapentin and cyclobenzaprine, as well as other muscle relaxants are not recommended for topical use as there is a lack of peer reviewed literature to support their use as a topical agent. No recent clinical documentation was submitted regarding the injured worker's condition to show that this medication has been effective in treating his pain and symptoms and therefore, the request would not be supported. There is also no indication that he has failed recommended oral medications. Furthermore, the requested compound cream contains medications that are not supported by the guidelines for topical use. Therefore, the request is not supported. As such, the request is not medically necessary.