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| Case Number: | CM15-0044953 | | |
| Date Assigned: | 04/30/2015 | Date of Injury: | 05/01/2012 |
| Decision Date: | 08/26/2015 | UR Denial Date: | 02/10/2015 |
| Priority: | Standard | Application Received: | 03/09/2015 |

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 49 year old female who sustained an industrial injury on May 1, 2012. She reported pain in her neck, right shoulder, right wrist/hand and her low back. Prior treatment includes MRI of the lumbar spine, cervical spine and upper extremities, TENS unit, ice therapy, physical therapy, acupuncture therapy and assistive devices. An evaluation of September 17, 2014 revealed in the injured worker had cervical pain with radiculitis, right shoulder pain, right wrist/hand pain and low back pain with sciatica. Diagnoses associated with the request included sprain of the lumbar spine. Her comprehensive treatment plan has included acupuncture, EMG/NCV of the bilateral lower and upper extremities, back cushion, TENS unit, trigger point impedance imaging/localized intense neurology-stimulation therapy, physical therapy and medications to include Capsaicin/Flurbiprofen/Tramadol/Methol/Camphor, Medrol patch, Flurbiprofen/Tramadol, and Cyclobenzaprine/Flurbiprofen.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective request for EMG/NCV of the bilateral lower extremities on date of service 10/2/13 and 3/20/14: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Electrodiagnostic testing (EMG/NCS).

Decision rationale: The California MTUS/ACOEM Guidelines state, "Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks." The ODG regarding nerve conduction studies (NCS) states, "Not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. EMGs (electromyography) are 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." The treating provider notes indicate diagnosis of Lumbar Radiculopathy in this injured worker. The objective findings on examination did not include evidence of neurologic dysfunction such as sensory, reflex, or motor system change. There were no symptoms or findings that define evidence of a peripheral neuropathy. There was insufficient information provided by the attending health care provider to establish the medical necessity or rationale for the requested electrodiagnostic studies. The request for an EMG/NCV of the bilateral lower extremities is not medically necessary and appropriate.

Retrospective request EMG/NCV of the bilateral upper extremities for date of service 10/2/13 and 3/20/14: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Electrodiagnostic testing (EMG/NCS).

Decision rationale: The California MTUS/ACOEM Guidelines state, "Electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks." The ODG regarding nerve conduction studies (NCS) states, "Not recommended". There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. EMGs (electromyography) are 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." The treating provider notes do indicate diagnosis of Cervical Radiculopathy in this injured worker. The injured worker has no symptoms or findings that define evidence of a peripheral neuropathy. The objective findings on examination did not include evidence of neurologic dysfunction such as sensory, reflex, or motor system change. There was insufficient information provided by the attending health care provider to establish the medical necessity or rationale for the requested electrodiagnostic studies. The request for an EMG/NCV of the bilateral upper extremities is not Medically necessary and appropriate.

Retrospective Capsaicin/Flurbiprofen/Tramadol/Menthol/Camphor for date of service 10/2/13 and 5/6/14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: According to the California MTUS Guidelines, topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, local anesthetics or antidepressants. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. In this case there is no documentation provided necessitating the requested treatment: Compound Retrospective Capsaicin/Flurbiprofen/Tramadol/Menthol/Camphor. One of the ingredients in this compound is Flurbiprofen. It is used as a topical NSAID. It has been shown in a meta-analysis to be superior to placebo during the first two weeks of treatment for osteoarthritis but either, not afterward, or with diminishing effect over another two-week period. There are no clinical studies to support the safety or effectiveness of Flurbiprofen in a topical delivery system (excluding ophthalmic) Medical necessity for the requested topical compound medication has not been established. The requested treatment is not medically necessary.

Retrospective request Medrox patch for date of service 10/2/13: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: According to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, muscle relaxants, local anesthetics or antidepressants. In this case, Medrox ointment contains methyl salicylate, menthol and capsaicin. Capsaicin is recommended only as an option in patients who have not responded to or are intolerant to other treatments. There is a lack of documentation that the injured worker is intolerant of other treatments. In addition, since the guidelines do not recommend several of the ingredients, there is no medical necessity for this compound. Medical necessity for the requested topical agent is not established. The requested Medrox ointment is not medically necessary.

Retrospective request Flurbiprofen/Tramadol for date of service 10/2/13: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: According to the California MTUS Guidelines, topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, local anesthetics or antidepressants. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. In this case there is no documentation provided necessitating the requested treatment: Compound Flurbiprofen/Tramadol. One of the ingredients in this compound is Flurbiprofen. It is used as a topical NSAID. It has been shown in a meta-analysis to be superior to placebo during the first two weeks of treatment for osteoarthritis but either, not afterward, or with diminishing effect over another two-week period. There are no clinical studies to support the safety or effectiveness of Flurbiprofen in a topical delivery system (excluding ophthalmic). Medical necessity for the requested topical compound medication has not been established. The requested treatment is not medically necessary.

Retrospective request Cyclobenzaprine/Flurbiprofen for date of service 5/6/14: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

Decision rationale: According to the California MTUS Guidelines, topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control including, for example, NSAIDs, opioids, capsaicin, local anesthetics or antidepressants. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. In this case there is no documentation provided necessitating the requested treatment: Compound Cyclobenzaprine/Flurbiprofen. One of the ingredients in this compound is Flurbiprofen. It is used as a topical NSAID. It has been shown in a meta-analysis to be superior to placebo during the first two weeks of treatment for osteoarthritis but either, not afterward, or with diminishing effect over another two-week period. There are no clinical studies to support the safety or effectiveness of Flurbiprofen in a topical delivery system (excluding ophthalmic). Medical

necessity for the requested topical compound medication has not been established. The requested treatment is not medically necessary.

Retrospective request back cushion for date of service 6/12/13: 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.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter -Lumbar supports.

Decision rationale: This request for Back Cushion is evaluated in light of the MTUS recommendations and Official Disability Guidelines (ODG). As per MTUS-ACOEM lumbar supports have not been shown to have any lasting benefit beyond the acute phase of low back pain. Official Disability Guidelines (ODG) does not recommend it for prevention. There is strong and consistent evidence that lumbar supports were not effective in preventing neck and back pain. Lumbar supports do not prevent LBP. A systematic review on preventing episodes of back problems found strong, consistent evidence that exercise interventions are effective and other interventions not effective, including stress management, shoe inserts, back supports, ergonomic/back education, and reduced lifting programs. This systematic review concluded that there is moderate evidence that lumbar supports are no more effective than doing nothing in preventing low-back pain. Official Disability Guidelines (ODG) recommends it as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific LBP (very low-quality evidence, but may be a conservative option). Among home care, workers with previous low back pain, adding patient-directed use of lumbar supports to a short course on healthy working methods may reduce the number of days when low back pain occurs, but not overall work absenteeism. Acute osteoporotic vertebral compression fracture management includes bracing, analgesics, and functional restoration. Medical Records of the injured worker indicate chronic back pain. There is no new injury. As per submitted medical records and Guidelines cited, the back cushion is not medically necessary and appropriate.

Retrospective purchase of a TENS unit for the lumbar spine for date of service 10/2/13: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-116.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrical nerve stimulation (TENS) Page(s): 115-116.

Decision rationale: As Per CA MTUS guidelines TENS unit is not recommended as a primary modality, but a one month home-based trial may be considered if used as an adjunct to a program of evidence-based functional restoration, with documentation of how often the unit was

used. MTUS Guideline does support rental of this unit at the most for one month, but Medical Records are not clear if this injured worker has tried TENS/EMS unit in a supervised setting and was there any functional benefit. A treatment plan that includes the specific short and long term goals of treatment with TENS unit cannot be located in the submitted Medical Records. The Requested Treatment TENS Unit is not medically necessary and appropriate

Retrospective request for 12 physical therapy visits for the lumbar spine 2 times a week for 6 weeks for dates of service 10/2/13 to 11/12/13: Overturned

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 prescription for Physical Therapy is evaluated in light of the MTUS recommendations for Physical Therapy MTUS recommends: 1) Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. 2) 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. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. The records are not clear if the injured worker had prior physical therapy, and what was the objective outcome. Also there is no mention of any significant change of symptoms or clinical findings, or acute flare up to support PT. The request for physical therapy is not medically necessary and appropriate.

Retrospective request for 12 acupuncture visits for the lumbar spine, 2 times a week for 6 weeks for date of service 10/2/13 to 11/12/13: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: This prescription for acupuncture is evaluated in light of the MTUS recommendations for acupuncture. The MTUS recommends an initial trial of 3-6 visits of acupuncture. Per the MTUS, "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." Medical necessity for any further acupuncture is considered in light of "functional improvement". The records are not clear if the injured worker had prior acupuncture therapy, and what was the objective outcome. There was no discussion by the treating physician regarding a decrease or intolerance to pain medications. Also 12 visits of acupuncture exceed the MTUS recommendation. Given the MTUS recommendations for use of acupuncture, the prescription for 12 visits is not medically necessary.

Retrospective request for trigger point impedance imaging/localized intense neuro-stimulation therapy for date of service 9/23/13: 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).

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 Chapter, Hyperstimulation analgesia.

Decision rationale: As per Official Disability Guidelines (ODG) Trigger point impedance imaging/localized intense neuro-stimulation therapy is not recommended until there are higher quality studies. Initial results are promising, but only from two low quality studies sponsored by the manufacturer ([REDACTED]). Localized manual high-intensity neurostimulation devices are applied to small surface areas to stimulate peripheral nerve endings (fibers), thus causing the release of endogenous endorphins. This procedure, usually described as hyperstimulation analgesia, has been investigated in several controlled studies. However, such treatments are time consuming and cumbersome, and require previous knowledge of the localization of peripheral nerve endings responsible for LBP or manual impedance mapping of the back, and these limitations prevent their extensive utilization. In this case, there is no compelling evidence presented by the treating provider that indicates the need for this therapy in this injured worker. Based on the currently available information in the submitted Medical Records of this injured worker, and per review of guidelines, the medical necessity for trigger point impedance imaging/localized intense neuro-stimulation therapy has not been established.