

Case Number:	CM15-0055916		
Date Assigned:	04/01/2015	Date of Injury:	08/27/2014
Decision Date:	05/15/2015	UR Denial Date:	02/25/2015
Priority:	Standard	Application Received:	03/24/2015

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, Washington

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 36-year-old male who reported an injury on 08/27/2014. The mechanism of injury occurred with the injured worker was struck by a coworker with a wooden beam. His diagnoses included post-traumatic cephalgia, sprain/strain, cervical spine, with bilateral upper extremity radiculopathy; contusion/sprain/strain, thoracic spine; contusion/sprain/strain lumbar spine, with bilateral lower extremity radiculopathy; sprain/strain shoulder, right, with tenodesis; sprain/strain elbow, right; lateral epicondylitis, right; rule out cubital tunnel syndrome, right; contusion, right, bilateral; stress/anxiety; palpitations, etiology unknown; and chest pain secondary to exposure to toxic paint fumes. The injured worker's past medical treatments included physiotherapy and chiropractic treatment. Diagnostic studies included a nerve conduction velocity study of the bilateral lower extremities, which revealed a normal EMG study of the lower extremities with no acute or chronic denervation potentials and a normal NCV study of the lower extremities, which did not reveal any electrophysiological evidence of peripheral nerve entrapment. Surgical history was not provided in the medical records. The injured worker's current medications included ibuprofen; dose and frequency were not provided. Treatment requested included Toradol 60 mg, capsaicin cream 0.025%, acupuncture, and physical therapy, and IF unit. A Request for Authorization has been submitted on 12/29/2014. However, the rationale for the requested treatment was not provided. The evaluation performed on 02/05/2015 indicated the injured worker had complaints of constant low back pain radiating to the right leg with associated symptoms of numbness. The symptoms were aggravated by walking standing, sitting, and bending. Upon examination, there was noted to be tenderness to

palpation to the lumbar paraspinal muscles. There was decreased range of motion of the lumbar spine with flexion. On the neurological examination, the injured worker had a normal motor strength. There was normal reflex, tone, and sensation was intact. The injured worker underwent electrodiagnostic studies that were noted to reveal a normal EMG of the lower extremities with no acute or chronic denervation potentials and a normal NCV study of the lower extremities that did not reveal any electrophysiological evidence of peripheral nerve entrapment.

IMR ISSUES, DECISIONS AND RATIONALES

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

Toradol 60mg: 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), Ketorolac (Toradol).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-68.

Decision rationale: According to the California MTUS Guidelines, NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain.

Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular, or renal vascular risk factors. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence to recommend 1 drug in this class over another based on efficacy. The documentation submitted for review failed to provide an objective increase in function and decrease in pain with the use of the requested NSAID. Additionally, the request as submitted failed to provide the duration and frequency in which this medication is to be taken. Therefore, the request is not supported. Given the above, the request for Toradol 60 mg is not medically necessary.

Capsaicin cream 0.025%: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Capsaicin.

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

Decision rationale: The California MTUS Guidelines state, capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. The documentation submitted for review failed to provide a rationale for the need of a topical analgesic. There was no indication the injured worker was unable to continue with oral formulation of pain medication. There was also no documentation of an objective increase in function and decrease in pain with the use of the requested topical analgesic. Therefore, the

continued use is not supported. Given the above, the request for capsaicin cream 0.025% is not medically necessary.

Acupuncture 2 times a week for 4 weeks, infrared, acupuncture to the neck and low back: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The California MTUS Guidelines state, acupuncture may be used as an option when pain medication is reduced or not tolerated, and may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Acupuncture can also be used to reduce pain, reduce inflammation, increase blood flow, increase range of motion, decrease the side effects of medication induced nausea, promote relaxation in an anxious patient, and reduce muscle spasm. The guidelines recommend time to produce functional improvement at 3 to 6 treatments with a frequency of 1 to 3 times per week and duration of 1 to 2 months. Acupuncture treatments may be extended if functional improvement is documented. The documentation submitted for review failed to provide a rationale for the need of the requested treatment. There was no documentation of objective functional deficits of the lumbar spine or neck to warrant the need of the requested treatment. Therefore, the request is not supported. Given the above, the request for acupuncture 2 times a week for 4 weeks, infrared, acupuncture to the neck and low back is not medically necessary.

Physical therapy 2 times a week for 6 weeks with multiple modalities to the neck, upper back and lower back: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Pain, Suffering, and the Restoration of Function Chapter, page 114.

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

Decision rationale: According to the California Guidelines, physical therapy allows for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine in the condition of myalgia and myositis, unspecified, at 9-10 visits over 8 weeks and neuralgia, neuritis, and radiculitis, unspecified at 8 to 10 visits over 4 weeks. The documentation submitted for review indicated the injured worker had previous physical therapy. However, the documentation failed to provide details regarding previous physical therapy, such as objective functional gains made. Additionally, the most recent clinical note failed to provide objective functional deficits of the neck, upper back, and lower back to warrant the need of continued supervised therapy. A clear rationale as to why the injured worker was unable to continue with a home exercise program was also not provided. Therefore, the request is not

supported. Given the above, the request for physical therapy 2 times a week for 6 weeks with multiple modalities to the neck, upper back and lower back is not medically necessary.

IF unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

Decision rationale: The California MTUS Guidelines state, interferential current stimulation is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise, and medications, and limited evidence of improvement on those recommended treatments alone. The documentation submitted for review failed to provide evidence the requested treatment would go in conjunction with any other recommended treatments, such as exercise and medications. Given interferential current stimulation is not recommended as an isolated intervention, the request is not supported. Additionally, the request as submitted failed to provide the duration and frequency in which the unit would be used. Therefore, the request is not supported. Given the above the request for IF unit is not medically necessary.