MAXIMUS Federal Services

Case Number:	CM15-0072505		
Date Assigned:	04/27/2015	Date of Injury:	06/28/2004
Decision Date:	08/11/2015	UR Denial Date:	03/20/2015
Priority:	Standard	Application Received:	04/15/2015

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 71 year old male, who sustained an industrial injury on 06/28/2004. He reported injury to his low back, right lower extremity, left side of the neck, left shoulder and right wrist. He was diagnosed with sprain of the lumbosacral spine and thoracic region and a contusion of the left hand. Treatment to date has included, x-rays, MRI of the lumbar spine, TENS unit, massage, splinting, cervical tractions, electrodiagnostic studies of the upper and lower extremities, chiropractic care, MRI of the left shoulder, MRI of the cervical spine, physical therapy and medications. According to a Doctor's First Report of Occupational injury dated 03/11/2015, the injured worker was seen for the cervical spine, thoracic spine, left trapezius and shoulder and left hand and wrist. Current complaints included pain in the cervical spine, left shoulder, lumbar region and left wrist. He also reported depression. Treatment plan included home exercise program, TENS, thumb spica with next visit, back support, acupuncture, cervical traction, MRI of the cervical and lumbar spine, left shoulder and left wrist, EMG/NCV (Electromyography/Nerve Conduction Velocity studies) of the upper and lower extremities and an evaluation for depression. Currently under review is the request for 1 TENS unit, 12 acupuncture visits, 12 cervical traction sessions, 1 MRI of the cervical spine, 1 MRI of the lumbar spine, 1 MRI of the left shoulder 1 EMG/NCV of the bilateral upper extremities and bilateral lower extremities and 1 prescription of LidoPro cream 121 grams.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 TENS unit: Upheld

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

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. On 03/23/2015, TENS unit was dispensed to the injured worker for home use-purchase. Progress note dated 04/01/2015 does not mention about any objective findings related to its use. 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 unit in a supervised setting and was there any functional benefit. Medical Records indicate past use of TENS unit, but there is no documentation about its benefits from the past use. The Requested Treatment TENS Unit is not medically necessary and appropriate.

12 acupuncture visits: 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". There is evidence that this injured worker has received treatment with acupuncture before, however the records are not clear about its functional benefits. 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.

12 cervical traction sessions: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173-174.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173,174.

Decision rationale: 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. Emphasis should focus on functional restoration and return of patients to activities of normal daily living. Although there is no compelling scientific evidence that supports effectiveness or ineffectiveness of traction, having such trial for this injured worker who had positive response to such treatment previously, is determined medically necessary and appropriate.

1 MRI of the cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 180. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck Chapter--Magnetic resonance imaging (MRI).

Decision rationale: MTUS/ACOEM state many patients with strong clinical findings of nerve root dysfunction due to disk herniation recover activity tolerance within one month; there is no evidence that delaying surgery for this period worsens outcomes in patients without progressive neurologic findings. Spontaneous improvement in MRI documented cervical disk pathology has been demonstrated with a high rate of resolution. As per ODG-criteria for MRI (magnetic resonance imaging): Chronic neck pain (= after 3 months conservative treatment), radiographs normal, neurologic signs or symptoms present Neck pain with radiculopathy if severe or progressive neurologic deficit, Chronic neck pain, radiographs show spondylosis, neurologic signs or symptoms present, Chronic neck pain, radiographs show old trauma, neurologic signs or symptoms present, Chronic neck pain, radiographs show bone or disc margin destruction, Suspected cervical spine trauma, neck pain, clinical findings suggest ligamentous injury (sprain), radiographs and/or CT "normal", Known cervical spine trauma: equivocal or positive plain films with neurological deficit, Upper back/thoracic spine trauma with neurological deficit Review of submitted medical records of injured worker mention about pain in the cervical spine, left shoulder, lumbar region and left wrist. No new injury is reported. The records are not clear about neurological findings, and there are no red flags. Without such evidence and based on guidelines cited, the request for repeat MRI of cervical spine is not medically necessary and appropriate.

1 MRI of the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

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--Magnetic resonance imaging (MRI).

Decision rationale: As per Official Disability Guidelines (ODG) - MRI (magnetic resonance imaging) is indicated for Lumbar spine trauma: trauma, neurological deficit, Thoracic spine trauma: with neurological deficit, Lumbar spine trauma: seat belt (chance) fracture (If focal, radicular findings or other neurologic deficit), Uncomplicated low back pain, suspicion of cancer, infection, other "red flags", Uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit, Uncomplicated low back pain, prior lumbar surgery, Uncomplicated low back pain, cauda equina syndrome, Myelopathy (neurological deficit related to the spinal cord), traumatic Myelopathy, painful Myelopathy, sudden onset, Myelopathy, stepwise progressive, Myelopathy, slowly progressive, Myelopathy, infectious disease patient, Myelopathy, oncology patient. Repeat MRI: When there is significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation) As per progress notes in the Medical Records, the injured worker does not appear to have significant changes in symptoms and signs, and the treating provider notes normal neurological exam, and there are no red flags. In the progress note of July 2013, spinal surgery does not consider the injured worker a surgical candidate. Therefore, the request for repeat MRI of Lumbar spine is not medically necessary and appropriate.

1 MRI of the left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208-209.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter-- Magnetic resonance imaging (MRI).

Decision rationale: As per ODG-criteria for MRI (magnetic resonance imaging): Acute shoulder trauma, suspect rotator cuff tear/impingement; over age 40; normal plain radiographs, Subacute shoulder pain, suspect instability/labral tear. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. Review of submitted medical records of injured worker mention about pain in the cervical spine, left shoulder, lumbar region and left wrist. No new injury is reported. As per progress notes in the Medical Records, the injured worker does not appear to have significant changes in symptoms and signs. The records are not clear about neurological findings, and there are no red flags. Without such evidence and based on guidelines cited, the request for repeat MRI Shoulder is not medically necessary and appropriate.

1 EMG/NCV of the bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

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 records of injured worker mention pain in the cervical spine, left shoulder, lumbar region and left wrist The objective findings on examination did not include evidence of neurologic dysfunction such as sensory, reflex, or motor system change. The injured worker is not presented as having radiculopathy and there were no symptoms or findings that define evidence of a peripheral neuropathy. Injured worker's previous EMG/NCV studies of bilateral upper extremities have been reportedly normal. There is insufficient information provided by the attending health care provider to establish the medical necessity or rationale for the repeat request of electrodiagnostic studies. The request for an EMG/NCV of the bilateral upper extremities is not medically necessary and appropriate.

1 EMG/ NCV of the bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. 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 records of injured worker mention pain in the cervical spine, left shoulder, lumbar region and left wrist The objective findings on examination did not include evidence of neurologic dysfunction such as sensory, reflex, or motor system change. The injured worker is not presented as having radiculopathy and there were no symptoms or findings that define evidence of a peripheral neuropathy. Injured worker's previous EMG/NCV studies of bilateral upper extremities have been reportedly normal. There is insufficient information provided by the

attending health care provider to establish the medical necessity or rationale for the repeat request of electrodiagnostic studies. The request for an EMG/NCV of the bilateral upper extremities is not medically necessary and appropriate.

1 prescription of LidoPro cream 121g: Upheld

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

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

Decision rationale: According to the California MTUS Guidelines (2009), topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anti-convulsants 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. Guidelines indicate that any compounded product that contains at least one non-recommended drug (or drug class) is not recommended for use. In this case, the requested topical analgesic compound, LidoPro cream, contains: Capsaicin, Lidocaine, Menthol and Methyl Salicylate. MTUS guidelines state that Lidocaine is not recommended for topical application for treatment of neuropathic pain. Capsaicin is recommended only as an option in patients who have not responded to or are intolerant to other treatments. Topical Lidocaine, in the formulation of a dermal patch (Lidoderm) is FDA approved for neuropathic pain, and used off-label for diabetic neuropathy. No other Lidocaine topical creams or lotions are indicated for neuropathic or non-neuropathic pain. Medical necessity for the requested topical analgesic compound has not been established. The requested topical compound is not medically necessary.