

Case Number:	CM15-0086003		
Date Assigned:	05/08/2015	Date of Injury:	01/05/2015
Decision Date:	06/29/2015	UR Denial Date:	04/10/2015
Priority:	Standard	Application Received:	05/05/2015

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: 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 47-year-old female patient who sustained an industrial injury on 01/05/2015. The injury was described as experiencing pain in the lumbar spine during the course of sitting whilst working for a prolonged time period. The symptoms progressed into the neck, and bilateral shoulders; along with radiation into the bilateral lower extremities. A doctor's first report of illness dated 03/24/2015 reported the patient with subjective complaint of frequent aching pains in the neck. The pain radiates to the arms and associated with neck weakness, and occipital headaches. She is diagnosed with cervical spine strain/sprain, thoracic strain/sprain, lumbar sprain/strain, and left shoulder sprain. She is prescribed modified work duty. Treatment rendered consisted of: physical examination, radiography study CTL/ spine, left shoulder and bilateral hands, prescribed Naproxen and Cyclotramadol cream. The plan of care involved recommendation for a functional capacity evaluation, initial course of chiropractic care and a transcutaneous nerve stimulator unit. Of note, the patient underwent a functional capacity evaluation on 04/07/2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic treatment 3x4 for the left shoulder; cervical thoracic and lumbar spine:

Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints, Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines x 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 58-60 of 127.

Decision rationale: Regarding the request for chiropractic care, Chronic Pain Medical Treatment Guidelines support the use of chiropractic care for the treatment of chronic pain caused by musculoskeletal conditions. Guidelines go on to recommend a trial of up to 6 visits over 2 weeks for the treatment of low back pain. With evidence of objective functional improvement, a total of up to 18 visits over 6 to 8 weeks may be supported. Within the documentation available for review, while a short course of chiropractic care appears to be reasonable, the currently requested 12 treatment sessions exceeds the initial trial recommended by guidelines of 6 visits and, unfortunately, there is no provision for modification of the current request. In light of the above issues, the currently requested chiropractic care is not medically necessary.

Cyclo/Tramadol cream: 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 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 111-113 of 127.

Decision rationale: Regarding the request for cyclo/tramadol cream, CA MTUS states that topical compound medications require guideline support for all components of the compound in order for the compound to be approved. Muscle relaxants are not supported by the CA MTUS for topical use. Furthermore, there is no clear rationale for the use of topical medications rather than the FDA-approved oral forms for this patient. Given all of the above, the requested cyclo/tramadol cream is not medically necessary.

One month home based trial of Neurostimulator TENS/EMS with supplies: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines x 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 114-121 of 127.

Decision rationale: Regarding the request for TENS/EMS, Chronic Pain Medical Treatment Guidelines state that transcutaneous electrical nerve stimulation (TENS) is not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a

noninvasive conservative option if used as an adjunct to a program of evidence-based functional restoration. Guidelines recommend failure of other appropriate pain modalities including medications prior to a TENS unit trial. Prior to TENS unit purchase, one month trial 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. Within the documentation available for review, there is no indication that the patient has chronic intractable pain after failure of other appropriate pain modalities including medications. Furthermore, it appears that the proposed device utilizes other types of electrical stimulation in addition to TENS, but they are not clearly identified such that the appropriate evidence-based criteria can be applied. In the absence of clarity regarding those issues, the currently requested TENS/EMS is not medically necessary.

Baseline functional capacity evaluation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 1 Prevention Page(s): 12. Decision based on Non-MTUS Citation x Official Disability Guidelines (ODG), Fitness for Duty Chapter, Functional Capacity Evaluation.

Decision rationale: Regarding request for functional capacity evaluation, Occupational Medicine Practice Guidelines state that there is not good evidence that functional capacity evaluations are correlated with a lower frequency of health complaints or injuries. ODG criteria for the use of a functional capacity evaluation include case management being hampered by complex issues such as prior unsuccessful return to work attempts, conflicting medical reporting on precautions and/or fitness for modified job, or injuries that require detailed explanation of a worker's abilities. Additionally, guidelines recommend that the patient be close to or at maximum medical improvement with all key medical reports secured and additional/secondary, conditions clarified. Within the documentation available for review, there is no indication that the patient is close to or at MMI with complex issues as outlined above. In the absence of clarity regarding those issues, the currently requested functional capacity evaluation is not medically necessary.