MAXIMUS Federal Services

Case Number:	CM13-0039066		
Date Assigned:	12/18/2013	Date of Injury:	01/09/2012
Decision Date:	02/11/2014	UR Denial Date:	09/23/2013
Priority:	Standard	Application	10/02/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Orthopedic Surgery and is licensed to practice in Michigan, Nebraska amd Texas. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 35-year-old female who reported an injury on 01/09/2012 after she lifted a heavy box weighing approximately 40 pounds, causing a sharp pain in her low back and right knee. The patient underwent an MRI that revealed an L5-S1 disc bulge without evidence of canal stenosis or neural foraminal narrowing. The patient received conservative treatment, to include physical therapy, acupuncture, epidural steroid injections and medications. The patient's most recent clinical examination findings included low back pain rated at a 7/10, radiating into the cervical spine and down to the left hip. The patient's diagnoses included a lumbar disc bulge and right lateral meniscus tear. The patient's treatment plan included physical therapy, continued medications and an orthopedic consultation for the right knee.

IMR ISSUES, DECISIONS AND RATIONALES

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

Request for electromyogram (EMG) bilateral lower extremities: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: The requested electromyogram of the bilateral lower extremities is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine recommends electrodiagnostic studies for patients who have radiating pain with suspicion of radiculopathy. The clinical documentation submitted for review does not support that the patient has any symptoms of radiculopathy or radiculitis. The physical findings indicate that the patient's pain does not radiate below the left hip. There was no documentation of weakness or dermatomal disturbed sensation. Therefore, the need for an electromyogram of the bilateral lower extremities is not medically necessary or appropriate.

Request for nerve conduction study (NCS) bilateral lower extremities: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: The requested nerve conduction study of the bilateral lower extremities is not medically necessary or appropriate. The American College of Occupational and Environmental Medicine recommends electrodiagnostic studies for patients who have radiating pain with suspicion of radiculopathy. The clinical documentation submitted for review does not support that the patient has any symptoms of radiculopathy or radiculitis. The physical findings indicate that the patient's pain does not radiate below the left hip. There was no documentation of weakness or dermatomal disturbed sensation. Therefore, the need for a nerve conduction study of the bilateral lower extremities is not medically necessary or appropriate.

Request for acupuncture sessions for the lumbar spine and right knee 2 times a week for 6 weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The requested acupuncture sessions for the lumbar spine and right knee at 2 times a week for 6 weeks are not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient had previously received acupuncture treatments. The California Medical Treatment Utilization Schedule recommends that continued acupuncture treatment be based on objective functional improvements. The clinical documentation submitted for review does not provide any evidence of objective functional improvement as a result of the prior treatments. As such, the requested acupuncture sessions for the lumbar spine and right knee at 2 times a week for 6 weeks are not medically necessary or appropriate.

Request for physical therapy sessions for the lumbar spine and right knee 2 times a week for 6 weeks: Upheld

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

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

Decision rationale: The requested physical therapy for the lumbar spine and right knee at 2 times a week for 6 weeks is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has previously received physical therapy. The California Medical Treatment Utilization Schedule recommends that patients be transitioned into a home exercise program to maintain improvement levels obtained during participation in skilled supervised therapy. The clinical documentation submitted for review does not provide any evidence that the patient is participating in a home exercise program. As a short course of physical therapy may be indicated to re-establish and re-educate the patient on a home exercise program, the requested 2 times a week for 6 weeks would be considered excessive. There were no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. As such, the requested physical therapy sessions for the lumbar spine and right knee at 2 times a week for 6 weeks are not medically necessary or appropriate.

Request for prescription of Norco 5/325 mg Q6-8H #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids On-Going Management Page(s): 78.

Decision rationale: The requested prescription of Norco 5/325 mg every 6 to 8 hours #90 is not medically necessary or appropriate. The California Medical Treatment Utilization Schedule recommends that the ongoing use of opioids in the management of a patient's chronic pain be supported by monitoring for aberrant behavior, increased functional benefit, a quantitative assessment of pain relief and managed side effects. The clinical documentation submitted for review does provide evidence that the patient has been monitored for aberrant behavior through the use of urine drug screens. However, there was no documentation of functional benefit or pain relief as a result of medication usage. Therefore, continued use would not be indicated. As such, the requested Norco 5/325 mg every 6 to 8 hours #90 is not medically necessary or appropriate.

Request for prescription of cyclobenzaprine 7.5mg BID #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) Page(s): 41.

Decision rationale: The requested prescription of cyclobenzaprine 7.5 mg twice a day #90 is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has persistent back pain. The California Medical Treatment Utilization Schedule recommends the use of this medication for short courses of treatment of an acute exacerbation of a patient's chronic low back pain. The clinical documentation submitted for review did not provide any evidence that the patient is experiencing an acute exacerbation of chronic pain. Additionally, the requested 90 tablets exceed the guideline recommendations of a

short course of treatment. There were no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. As such, the requested cyclobenzaprine 7.5 mg twice a day #90 is not medically necessary or appropriate.

Request for prescription of Capsaicin 0.025% Flurbiprofen 30% Methyl Salicylate 4% cream in Lipoderm base 2-3 times/day topically 240gm: Upheld

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

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

Decision rationale: The requested prescription for capsaicin 0.025% / flurbiprofen 30% / methyl salicylate 4% cream in a Lipoderm base 2 to 3 times a day topically 240 gm is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has pain that would benefit from medication management. The California Medical Treatment Utilization Schedule does not support the use of topical agents, as there is not enough scientific data to support the efficacy of these compounds. The requested medication contains capsaicin 0.025%. The California Medical Treatment Utilization Schedule recommends the use of capsaicin only in cases where the patient is intolerant or unresponsive to other treatments. The clinical documentation submitted for review does not provide any evidence that the patient is intolerant or unresponsive to other treatments, to include oral analgesics. Additionally, the compound includes flurbiprofen. The California Medical Treatment Utilization Schedule does not recommend non-steroidal anti-inflammatory drugs as a topical agent unless there is documentation that the patient is intolerant of oral anti-inflammatory medications or oral medications are contraindicated for the patient. The California Medical Treatment Utilization Schedule does recommend the use of methyl salicylate 4% in the treatment of osteoarthritic pain. However, as the requested compound contains elements that are not supported by guideline recommendations, the entire medication is not supported. As such, the requested capsaicin 0.025% / flurbiprofen 30% / methyl salicylate 4% cream in a Lipoderm base 2 to 3 times a day topically 240 gm is not medically necessary or appropriate.

Request for prescription of Flurbiprofen 30% Tramadol 20% cream in Lipoderm base 2-3 times/day topically 240gm: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111. Decision based on Non-MTUS Citation Effectiveness of topical administration of opioids in palliative care: a systematic review B LeBon, et al - Journal of pain and symptoms, 2009 – Elsevier.

Decision rationale: The requested flurbiprofen 30% / Tramadol 20% cream in a Lipoderm base 2 to 3 times a day topically 240 gm is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has pain that would benefit from medication treatment. However, the California Medical Treatment Utilization Schedule does not recommend the usage of topical agents, as they are largely experimental, and there are few scientific studies to support the efficacy of these medications. Additionally, the California Medical Treatment Utilization Schedule recommends the topical use of non-steroidal

anti-inflammatory drugs for patients who are intolerant of oral anti-inflammatory agents. The clinical documentation submitted for review does not provide any evidence that the patient is intolerant of oral non-steroidal anti-inflammatory drugs or that those drugs are contraindicated for this patient. Additionally, peer-reviewed literature does not support the use of opioids in topical analgesics as there is no scientific evidence to support the efficacy of this type of medication used as a topical agent. As such, the requested flurbiprofen 30% / Tramadol 20% cream in a Lipoderm base 2 to 3 times a day topically 240 gm is not medically necessary or appropriate.

Request for DNA testing: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Genetic testing for potential opioid abuse.

Decision rationale: The requested DNA testing is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has pain deficits that would benefit from medication management. However, the Official Disability Guidelines do not recommend the use of DNA testing to determine the patient's tendencies towards effective behavior. As this type of testing is not supported by guideline recommendations, it would not be indicated. Additionally, there were no exceptional factors noted within the documentation to support extending treatment beyond guideline recommendations. As such, the requested DNA testing is not medically necessary or appropriate.

Request for Interferential (IF) unit: Upheld

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

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

Decision rationale: The requested interferential unit is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has been treated conservatively with several modalities. The California Medical Treatment Utilization Schedule recommends the use of an interferential unit for patients who have chronic pain recalcitrant to medications and conservative management and is based on a 30-day clinical trial to establish the efficacy of the treatment modality. Additionally, it is recommended that this be used as an adjunct to therapy to an active therapy program. The clinical documentation submitted for review does not provide any evidence that the patient is participating in a home exercise program. Additionally, there was no documentation that the patient has undergone a trial of this type of therapy. Therefore, the efficacy cannot be determined. As such, the requested interferential unit is not medically necessary or appropriate.

Request for Vital Wrap system: Upheld

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

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 Cold/heat packs and Knee and Leg Chapter Continuous Flow Cryotherapy.

Decision rationale: The requested Vital Wrap system is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has pain that would benefit from medical management. However, the Official Disability Guidelines do not support the use of continuous flow cryotherapy in the absence of surgical intervention for the knee. The clinical documentation submitted for review does not provide any evidence that the patient is a surgical candidate for the knee at this time. Therefore, this type of treatment would not be indicated for the knee. Additionally, the clinical documentation supports that the patient has a low back injury. The Official Disability Guidelines recommend the use of hot and cold applications. However, continuous flow cryotherapy is not supported for back pain. There is no documentation that the patient has failed to respond to hot and cold applications. There were no exceptional factors noted within the documentation to extend treatment beyond guideline recommendations. As such, the requested Vital Wrap system is not medically necessary or appropriate.