

<b>Case Number:</b>	CM15-0019033		
<b>Date Assigned:</b>	03/11/2015	<b>Date of Injury:</b>	05/14/2014
<b>Decision Date:</b>	04/14/2015	<b>UR Denial Date:</b>	01/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/02/2015

### 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: Emergency 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:

This 59-year-old male has reported knee and back pain after an injury on 05/14/2014 or 6/25/13. According to a Doctor's First Report of Occupational Injury dated 07/15/2014, the date of injury was 6/25/13. The injury was a contusion to the knee. There was ongoing bilateral knee pain and low back pain. There was no treatment history. The low back pain radiated to the left lower extremity. The left knee was tender with edema, had a positive drawer and McMurray's, and had a range of motion of "ext -10". The low back had painful range of motion and spasm. The diagnoses included lumbar spine sprain/strain, right knee sprain/strain and left knee sprain/strain. The treatment plan included acupuncture, electromyography/nerve conduction velocity studies of the lower extremities, MRI of the lumbar spine, TENS unit, Function Capacity Evaluation, urinalysis for drug compliance, chiropractic care and physical therapy, Localized Intense Neurostimulation Therapy and topical compound creams. The work status was apparently "temporarily totally disabled". The treating physician was an MD, with a listed specialty of Occupational Medicine. The report did not provide the specific indications for any of the requested items. Subsequent treating physician reports do not provide any additional information regarding medical necessity for the requested items, but do show that treatment proceeded with shockwave therapy for the knee and low back, acupuncture, and LINT/TPII. On 12/31/14, Utilization Review non-certified items now under Independent Medical Review citing the MTUS and the Official Disability Guidelines. Utilization Review referred to a medical report of 7/15/14 as the source of the most current information regarding these requests, with a request date of 10/10/14.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Retrospective Request for an X-Ray of the Bilateral Lower Extremities (DOS: 12/10/2014): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Knee Chapter.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints  
Page(s): 332-335, 341, 343, 344-345, 347.

**Decision rationale:** There is no information in the available records regarding the need for radiographs of the entire lower extremities. The only references are to knee pain, which is not equivalent to the "lower extremities". The treating physician has not provided an exam of the lower extremities or a relevant history indicating a condition for which radiographs of the extremities might be indicated. With respect to the knees alone, per the ACOEM Guidelines Page 341, special studies are not needed to evaluate most knee conditions until after a period of conservative care and observation. Page 343 lists surgical indications: activity limitation for more than one month, failure of an exercise program. The available reports do not adequately explain the kinds of conservative care already performed. The necessary components of the knee exam are not present, see pages 332-335 of the ACOEM Guidelines. There is no evidence of a period of conservative care prior to prescribing the imaging, and the necessary components of the examination are not provided. The imaging is not medically necessary based on the MTUS and lack of specific indications.

### **Retrospective Request for an MRI of both Lower Extremities (DOS: 12/10/2014): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints. Decision based on Non-MTUS Citation ODG, Knee & Leg Chapter.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints  
Page(s): 332-335, 341, 343, 344-345, 347.

**Decision rationale:** There is no information in the available records regarding the need for imaging of the entire lower extremities. The only references are to knee pain, which is not equivalent to the "lower extremities". The treating physician has not provided an exam of the lower extremities or a relevant history indicating a condition for which radiographs of the extremities might be indicated. With respect to the knees alone, per the ACOEM Guidelines Page 341, special studies are not needed to evaluate most knee conditions until after a period of conservative care and observation. Page 343 lists surgical indications: activity limitation for more than one month, failure of an exercise program. The available reports do not adequately explain the kinds of conservative care already performed. The necessary components of the knee exam are not present, see pages 332-335 of the ACOEM Guidelines. There is no evidence of a period of conservative care prior to prescribing the imaging, and the necessary components of

the examination are not provided. The imaging is not medically necessary based on the MTUS and lack of specific indications.

**Retrospective Request for an Open MRI of the Lumbar Spine (DOS: 12/10/2014): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304: table 12-8. Decision based on Non-MTUS Citation ODG, Low Back Chapter.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303, 290.

**Decision rationale:** The treating physician has not described the clinical evidence of significant pathology discussed in the MTUS, such as "Unequivocal objective findings that identify specific nerve compromise on the neurologic examination". No "red flag" conditions are identified. The treating physician has not provided an adequate clinical evaluation, as outlined in the MTUS ACOEM Guidelines Pages 291-296. The treating physician has not provided specific indications for performing an MRI. This patient does not fit the MTUS criteria for invasive procedures, such as epidural steroid injection or spine surgery, regardless of any proposed MRI findings. MRI of the lumbar spine is not indicated in light of the paucity of clinical findings suggesting any serious pathology; increased or ongoing pain, with or without radiation, is not in itself indication for MRI. An MRI of the lumbar spine is not medically necessary based on lack of sufficient indications per the MTUS.

**Retrospective Request for an EMG/NCV of the Bilateral Lower Extremities (DOS: 12/10/2014): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 303. Decision based on Non-MTUS Citation ODG, Low Back Chapter.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chapter 13 Knee Complaints, Chapter 14 Ankle and Foot Complaints Page(s): 303, 309; 366, 377; 343, 347.

**Decision rationale:** There are no reports from the prescribing physician which adequately describe neurologic findings that necessitate electrodiagnostic testing. Non-specific pain or paresthesias are not an adequate basis for performance of EMG or NCV. Medical necessity for electrodiagnostic testing is established by a clinical presentation with a sufficient degree of neurologic signs and symptoms to warrant such tests. Non-specific, non-dermatomal extremity symptoms are not sufficient alone to justify electrodiagnostic testing. The MTUS, per the citations listed above, outlines specific indications for electrodiagnostic testing, and these indications are based on specific clinical findings. Based on the available clinical information, there are no neurologic abnormalities and no specific neurologic symptoms. There are therefore no indications for electrodiagnostic testing. Based on the current clinical information, electrodiagnostic testing is not medically necessary, as the treating physician has not provided the specific indications and clinical examination outlined in the MTUS.

**Retrospective Request for Acupuncture, 12-sessions, 2 times a week for 6 weeks (DOS: 12/10/2014): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** 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. The treating physician has not provided the specific indications for acupuncture as listed in the MTUS. There is no discussion of issues with pain medications, or functional recovery in conjunction with surgery and physical rehabilitation. An initial course of acupuncture is 3-6 visits per the MTUS. The prescription is for 12 visits, which exceeds the quantity recommended in the MTUS. Given that the focus of acupuncture is functional improvement, function (including work status or equivalent) must be addressed as a starting point for therapy and as a measure of progress. As discussed in the MTUS, chronic pain section, the goal of all treatment for chronic pain is functional improvement, in part because chronic pain cannot be cured. An initial course of acupuncture is not medically necessary based on a prescription which exceeds the quantity recommended in the MTUS, and lack of specific indications per the MTUS.

**Retrospective Request for Physiotherapy, 12-sessions, 2 times a week for 6-weeks (DOS: 12/10/2014): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98-99. Decision based on Non-MTUS Citation ODG Low Back Chapter.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Introduction, functional improvement; Physical Medicine Page(s): 9; 98-99.

**Decision rationale:** The treating physician has not provided an adequate prescription, which must contain diagnosis, duration, frequency, and treatment modalities, at minimum. Per the MTUS, Chronic Pain section, functional improvement is the goal rather than the elimination of pain. The maximum recommended quantity of Physical Medicine visits is 10, with progression to home exercise. The treating physician has not stated a purpose for the current physical therapy prescription. It is not clear what is intended to be accomplished with this physical therapy, given that it will not cure the pain and there are no other goals of therapy. The current physical therapy prescription exceeds the quantity recommended in the MTUS. There are no physician reports outlining a specific need for Physical Medicine. There are no functional goals. Given the completely non-specific prescription for physical therapy in this case, it is presumed that the therapy will rely on passive modalities, which is not recommended for chronic pain. Physical Medicine for chronic pain should be focused on progressive exercise and self care, with

identification of functional deficits and goals, and minimal or no use of passive modalities. A non-specific prescription for "physical therapy" in cases of chronic pain is not sufficient. "Temporarily totally disabled" status is not an appropriate baseline for initiation of a physical therapy program emphasizing functional improvement. Physical Medicine is not medically necessary based on the MTUS, an excessive number of visits prescribed, and lack of sufficient emphasis on functional improvement.

**Retrospective Request for Chiropractic Treatment, 12-sessions, 2 times a week for 6-weeks (DOS: 12/10/2014): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-299, Chronic Pain Treatment Guidelines Manipulation Page(s): 58.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-60.

**Decision rationale:** Per the MTUS for Chronic Pain, the purpose of manual medicine is functional improvement, progression in a therapeutic exercise program, and return to productive activities (including work). Given that, the focus of manipulative therapy is functional improvement, "temporarily totally disabled" is not an appropriate starting point for therapy, and does not represent a sufficient emphasis on restoring function. Per the MTUS, chiropractic manipulation is not recommended for the "Ankle & Foot, Carpal tunnel syndrome, Forearm, Wrist, & Hand, Knee". Treatment in this case appears to include the knee. Per the MTUS for Chronic Pain, a trial of 6 visits of manual therapy and manipulation may be provided over 2 weeks, with any further manual therapy contingent upon functional improvement. 12 visits exceed the recommended initial course per the MTUS. No manual and manipulative therapy is medically necessary based on the lack of emphasis on functional restoration and a prescription which exceeds that recommended in the MTUS.

**Retrospective Request for a Right Knee Brace (DOS: 12/10/2014): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Knee & Leg Chapter.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 338, 340, 346.

**Decision rationale:** The ACOEM Guidelines page 340 state that a knee brace can be used for patellar instability, ACL tear, or MCL instability, although its benefits may be more related to increasing the patient's confidence than strictly medical. A brace would usually be needed if the patient will be stressing the knee under load, such as climbing or carrying. For the average patient, using a brace is usually unnecessary. In all cases, braces need to be properly fitted and combined with a rehabilitation program. On page 338, a knee sleeve is an option for patella femoral syndrome. Page 346 recommends short duration immobilization after acute injury, and functional bracing as part of a rehab program. Not recommended is prophylactic bracing or prolonged bracing for anterior cruciate ligament deficiency. In this case, the treating physician

did not discuss the kind of brace prescribed or the specific indications. The indications in the MTUS were not listed. The brace is therefore not medically necessary.

**Retrospective Request for TENS (DOS: 12/10/2014): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines TENS Units Page(s): 114, 116.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain Page(s): 114-117.

**Decision rationale:** No physician reports address the specific medical necessity for a TENS unit. The MTUS for Chronic Pain lists the indications for TENS, which are primarily neuropathic pain, a condition not present in this patient. Other recommendations, including specific components of the treatment plan, are listed in the MTUS. The necessary kind of treatment plan is not present, including a focus on functional restoration with a specific trial of TENS alone. Given the lack of clear indications in this injured worker (primary reason), and the lack of any clinical trial or treatment plan per the MTUS (secondary reason), a TENS unit is not medically necessary.

**Retrospective Request for a TPII & Localized Intense Neurostimulation (LINT) Therapy to the Lumbar Spine (DOS: 12/10/2014): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NEMS Page(s): 121.

**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, Hyper-stimulation analgesia.

**Decision rationale:** The MTUS does not address TPII and LINT. The Official Disability Guidelines recommend against these procedures based on the lack of medical evidence. The TPII and LINT are therefore not medically necessary.

**Retrospective Request for a Functional Capacity Evaluation (DOS: 12/10/2014): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 48. Decision based on Non-MTUS Citation ODG Fitness for Duty Chapter.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 81. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness for Duty chapter, Functional capacity evaluation and Other Medical Treatment Guidelines American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 7, Pages 137-8, discussion of IME recommendations (includes functional capacity evaluation).

**Decision rationale:** The ACOEM Guidelines do not recommend functional capacity evaluations ("FCE") as an evaluation for disability. The ACOEM guidelines pages 137-8, in the section referring to Independent Medical Evaluations (which is not the context in this case), state "there is little scientific evidence confirming that functional capacity evaluations predict an individual's actual capacity to perform in the workplace" and " it is problematic to rely solely upon the functional capacity evaluation results for determination of current work capability and restrictions." The MTUS for Chronic Pain and the Official Disability Guidelines recommend a functional capacity evaluation for Work Hardening programs, which is not the context in this case. The Official Disability Guidelines state that a functional capacity evaluation is "Recommended prior to admission to a Work Hardening (WH) Program, with preference for assessments tailored to a specific task or job. Not recommend routine use as part of occupational rehab or screening, or generic assessments in which the question is whether someone can do any type of job generally." The current request does not meet this recommendation, as it appears to be intended for general rather than job-specific use. The treating physician has not defined the components of the functional capacity evaluation. Given that there is no formal definition of a functional capacity evaluation, and that a functional capacity evaluation might refer to a vast array of tests and procedures, medical necessity for a functional capacity evaluation (assuming that any exists), cannot be determined without a specific prescription which includes a description of the intended content of the evaluation. The MTUS for Chronic Pain, in the Work Conditioning-Work Hardening section, mentions a functional capacity evaluation as a possible criterion for entry, based on specific job demands. The treating physician has not provided any information in compliance with this portion of the MTUS. The functional capacity evaluation in this case is not medically necessary based on lack of medical necessity and lack of a sufficiently specific prescription.

**Retrospective Request for a Urine Drug Screen - Drug Compliance (DOS: 12/10/2014):**  
Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 43, 78.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, drug screens, steps to avoid misuse/addiction; urine drug screen to assess for the use or the presence of illegal drugs; Use of drug screening or inpatient treatment with issues of abuse, addiction, or poor pain control; Opioid contracts: (9) Urine drug screens may be required; Opioids, steps to avoid misuse/addiction: c) Frequent random urine toxicology screens Page(s): 77-80, 94; 43, 77; 78; 89; 94. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Urine Drug Testing (UDT) in patient-centered clinical situations, criteria for use and Other Medical Treatment Guidelines Other Medical Treatment Guideline or Medical Evidence: Updated ACOEM Guidelines, 8/14/08, Chronic Pain, Page 138, urine drug screens.

**Decision rationale:** The treating physician has not provided any specific information regarding the medical necessity for a urine drug screen. No medications were listed, and the need for management via a urine drug screen is not explained. Medical necessity for a urine drug screen is predicated on a chronic opioid therapy program conducted in accordance with the

recommendations of the MTUS, or for a few other, very specific clinical reasons. There is no evidence in this case that opioids are prescribed. The treating physician has not listed any other reasons to do the urine drug screen. The details of testing have not been provided. The citations above list indications and procedural details for drug screening. None of this kind of information was presented. There is no apparent medical necessity for a urine drug screen.

**Retrospective Request for Compound Cream: Flurbiprofen (20%) and Tramadol (20%), 210gms with 1 refill (DOS: 12/10/2014): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain; Topical Medications Page(s): 60; 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain chapter, Topical analgesics.

**Decision rationale:** No physician reports discuss the specific indications and medical evidence in support of the topical medications prescribed in this case. The treating physician has not discussed the ingredients of this topical agent and the specific indications for this injured worker. Per the MTUS page 60, medications are to be given individually, one at a time, with assessment of specific benefit for each medication. Provision of multiple medications simultaneously is not recommended. In addition to any other reason for lack of medical necessity for these topical agents, they are not medically necessary on this basis at minimum. The Official Disability Guidelines state that "Custom compounding and dispensing of combinations of medicines that have never been studied is not recommended, as there is no evidence to support their use and there is potential for harm." The compounded topical agent in this case is not supported by good medical evidence and is not medically necessary based on this Official Disability Guidelines recommendation. The MTUS states that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Per the MTUS, topical NSAIDs for short term pain relief may be indicated for pain in the extremities caused by osteoarthritis or tendonitis. There is no good evidence supporting topical NSAIDs for shoulder or axial pain. The treating physician did not provide any indications or body part intended for this NSAID. Note that topical flurbiprofen is not FDA approved, and is therefore experimental and cannot be presumed as safe and efficacious. Non-FDA approved medications are not medically necessary. There is no good medical evidence in support of topical opioids like tramadol. The topical compounded medication prescribed for this injured worker is not medically necessary based on the MTUS, lack of medical evidence, and lack of FDA approval.

**Retrospective Request for a Pain Management Referral (DOS: 12/10/2014): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, page 127 and on the Non-MTUS ODG Low Back Chapter.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 306.

**Decision rationale:** The MTUS does not provide references to "pain management". Some of the body part chapters, as cited above, recommend the option of a PMR referral for non-surgical issues. In this case, the treating physician, who is an MD specializing in Occupational Medicine, has not provided any indications for a referral to "pain management". The treating physician has not described any complex pain problems or reasons that he cannot treat the pain using usual medications. The treating physician made this referral at the initial visit, indicating that there had been no failure of usual conservative methods. The referral is not medically necessary based on the lack of specific indications.