MAXIMUS Federal Services

Case Number:	CM15-0124435		
Date Assigned:	07/15/2015	Date of Injury:	01/07/2015
Decision Date:	09/14/2015	UR Denial Date:	06/04/2015
Priority:	Standard	Application Received:	06/29/2015

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: Arizona, Michigan
Certification(s)/Specialty: Preventive Medicine, Occupational 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 55-year-old male, who sustained an industrial injury on 1/7/2015. He reported injury of the left eye, head face, neck, chest, back and shoulders due to a motor vehicle accident. The injured worker was diagnosed as having cervical sprain/strain, lumbar sprain/strain, lumbar radiculopathy, shoulder sprain/strain, muscle spasm, headache, chest contusion, sleep disorder, numbness and tingling, depression, and myalgia and myositis. Treatment to date has included medications, x-rays, sutures to the left eye, CT scan, rest, acupuncture, oriental medicine, and electro diagnostic studies (4/23/2015). The request is for acupuncture for the cervical spine, acupuncture for the lumbar spine, chiropractic manipulation for the cervical spine, chiropractic manipulation for the lumbar spine, Cyclobenzaprine 5% cream, Deprizine oral suspension, Dicopanol oral suspension, Fanatrex oral suspension, Ketoprofen 20% cream, physical therapy for the cervical spine, physical therapy for the lumbar spine, Synapryn oral suspension, Tabradol oral suspension, and Terocin patches. On 3/31/2015, he complained of neck pain rated 7-9/10, and with radiation into the upper extremities; upper back pain he rated 7-8/10 with pain around the chest and ribs; right shoulder, hand and wrist rated 3-6/10; low back pain he rated 8-9/10 with occasional radiating pain down the bilateral lower extremities down to the ankles; and bilateral hip pain rated 4-6/10 with associated numbness and tingling in the hips and thighs. He reported having difficulty with activities of daily living including personal hygiene. The treatment plan included acupuncture and adjunctive physiotherapies, and orthopedic consult. On 4/7/2015, he complained of headaches, neck pain rated 7/10, right shoulder pain rated 7/10, right elbow pain rated 7/10, right wrist pain rated 7/10,

left ribs pain rated 7/10, and low back pain with muscle spasms rated 7/10. The treatment plan included: Deprizine, Dicopanol, Fanatrex, Synapryn, Tabradol, Cyclobenzaprine cream, and Ketoprofen cream, and physical therapy, chiropractic treatment and Terocin patches. On 4/9/2015, indicated he had been authorized for acupuncture and physiotherapies. He complained of neck pain rated 7-9/10, upper back pain rated 7-8/10, right shoulder, hand and wrist pain rated 3-6/10, low back pain rated 8-9/10, and bilateral hip pain rated 4-6/10. The treatment plan included acupuncture and adjunctive physiotherapies, magnetic resonance imaging of the cervical and lumbar spine, neurological consult, and electro diagnostic studies of the upper and lower extremities. On 4/13/2015, an orthopedic consultation revealed he complained of headaches, and pain to the neck, right shoulder, right elbow, right wrist, left ribs, and low back. The treatment plan included Deprizine, Dicopanol, Fanatrex, Synapryn, Tabradol, Cyclo-benzaprine cream, and Ketoprofen cream, and physical therapy and chiropractic treatment, and Terocin patches. On 4/23/2015, electro diagnostic studies revealed multi-level bilateral cervical radiculopathy or possible multiple upper extremity nerve involvement. On 5/5/2015, he had continued complaint of pain to the neck, right shoulder, right elbow, right wrist, left rib, and low back. The treatment plan included Deprizine, Dicopanol, Fanatrex, Synapryn, Tabradol, Cyclobenzaprine cream, and Ketoprofen cream, physical therapy, chiropractic care, and acupuncture. His work status is unclear. On 5/11/2015, he had continued complaint of pain to the neck, upper back, and right upper extremity, low back and bilateral hips. The treatment plan included orthopedic consultation, magnetic resonance imaging of the cervical and lumbar spine, and neurological consultation electro diagnostic studies. On 6/9/2015, he complained of headaches, neck pain with muscle spasms, burning right shoulder pain with radiation down the arm to the fingers, right elbow pain, right wrist pain, left rib pain, low back pain with muscle spasms and radiation into the lower extremities. Physical findings revealed tenderness in the neck area, right shoulder area, right elbow, right wrist, and low back region. The examination of the chest and rib cage area are being deferred to a specialist. The treatment plan included physical therapy, chiropractic treatment, and acupuncture, and Deprizine, Dicopanol, Fanatrex, Synapryn, Tabradol, Cyclobenzaprine cream, and Ketoprofen cream.

IMR ISSUES, DECISIONS AND RATIONALES

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

Ketoprofen 20% cream, 167gm: Upheld

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

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

Decision rationale: The CA MTUS recommend topical analgesics as an option, primarily for neuropathic pain when trials of anti-depressants and anti-convulsants have failed. Ketoprofen is considered a non-steroidal anti-inflammatory drug (NSAID), and per the CA MTUS guidelines, it is a non-FDA approved agent for topical application. The records indicate the injured worker has been utilizing Ketoprofen cream since at least December 2014. According to the CA MTUS, all therapies must be focused on the goal of functional restoration rather than just the elimination

of pain and assessment efficacy is accomplished by reporting functional improvement. The records are unclear regarding his work status. The records do not indicate a trial and/or failure of anti-depressants and anti-convulsants. In addition, Ketoprofen is not FDA approved for topical application. Therefore, the request for Ketoprofen 20% cream, 167 gm is not medically necessary.

Cyclobenzaprine 5% cream, 110gm: 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 Topical analgesics Page(s): 111-113.

Decision rationale: The physician has stated the requested treatment Cyclobenzaprine 5% cream contains Cyclobenzaprine hydrochloride and other proprietary ingredients. Medical necessity cannot be determined for unspecified compounds, and unpublished ingredients cannot be assumed to be safe or effective. Cyclobenzaprine 5% cream is not medically necessary on this basis alone. The CA MTUS guidelines do not recommend any compounded product that contains at least one drug (or drug class) that is not recommended. Cyclobenzaprine is considered to be a muscle relaxant. The MTUS indicates there is no evidence for use of any muscle relaxant as a topical product. Based on these findings, the request of Cyclobenzaprine 5% cream, 110 gm is not medically necessary.

Synapryn 10mg in 1ml oral suspension 500ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids and Tramadol (Ultram) Page(s): 75 and 113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Physician dispenses drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Glucosamine (and Chondroitin Sulfate); Opioids Page(s): 50, 74-95.

Decision rationale: The physician has stated that Synapryn contains Tramadol, and glucosamine sulfate, as well as other proprietary ingredients. Medical necessity cannot be determined for unspecified compounds, and unpublished ingredients cannot be assumed to be safe or effective. The reason for combining these medications is not discussed in any physician report. Given that Tramadol is generally a prn medication to be used as little as possible, and that glucosamine (assuming a valid indication) is to be taken regularly regardless of acute symptoms, the combination product is illogical and not indicated. Tramadol is prescribed without clear evidence of the considerations and expectations found in the CA MTUS and similar guidelines. Tramadol is an opioid. Opioids may be considered for chronic pain, neuropathic pain, osteoarthritis, and for cancer pain. Opioids are minimally indicated, if at all, for chronic back pain. The prescribing physician does not specifically address function with respect to prescribing opioids, and does not address the other recommendations in the CA MTUS. There is no evidence that the treating physician has utilized a treatment plan NOT using opioids, and that the patient "has failed a trial of non-opioid analgesics". The CA MTUS provides support for treating moderate arthritis pain,

particularly knee OA, with glucosamine sulphate. Other forms of glucosamine are not supported by good medical evidence. The treating physician in this case has not provided evidence of the form of glucosamine in Synapryn, and that it is the form recommended in the CA MTUS and supported by the best medical evidence. Should there be any indication for glucosamine in this case, it must be given as a single agent apart from other analgesics, particularly analgesics like Tramadol which are habituating. Synapryn is not medically necessary based on the CA MTUS, lack of good medical evidence, and lack of a treatment plan for chronic opioid therapy consistent with the MTUS. Therefore, the request for Synapryn 10mg per 1 ml oral suspension 500 ml is not medically necessary.

Tabradol 1mg per ml oral suspension 250ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Antispasmodics Page(s): 54. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Physician dispense drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MSM (methylsulfonylmethane); Muscle relaxants (for pain) Page(s): 63-66. Decision based on Non-MTUS Citation Drugs.com.

Decision rationale: The physician reported that Tabradol contains Cyclobenzaprine, methlsulfonylmethane and other proprietary ingredients. Methlsulfonylmethane is also known as MSM. Per Drugs.com, "MSM is commonly used for osteoarthritis, but may also benefit in alleviating GI upset, musculoskeletal pain, and allergies; boosting the immune system; and fighting antimicrobial infection". Cyclobenzaprine is a muscle relaxant. The CA MTUS for Chronic Pain does not recommend muscle relaxants for chronic pain. Non-sedating muscle relaxants are an option for short-term exacerbations of chronic low back pain. Medical necessity cannot be determined for unspecified compounds, and unpublished ingredients cannot be assumed to be safe or effective. The MTUS states that treatment with Cyclobenzaprine should be brief, and that the addition of Cyclobenzaprine to other agents is not recommended. In this case, Cyclobenzaprine is added to other agents and the oral suspension form plus topical is experimental and unproven. Prescribing was not for a short-term exacerbation. Based on the findings Tabradol does not meet the criteria set by the CA MTUS guidelines. Therefore, the request for Tabradol 1mg per ml oral suspension 250ml is not medically necessary.

Deprizine 15mg per ml oral suspension 250ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Physician dispense drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain; NSAIDs, GI symptoms & cardiovascular risk Page(s): 60, 68-69.

Decision rationale: The prescribing physician indicated that Deprizine contains ranitidine and other proprietary ingredients. Ranitidine is prescribed without any rationale provided. If

ranitidine is prescribed as co-therapy with an NSAID (non-steroidal anti-inflammatory drug), ranitidine is not the best drug. Note the MTUS recommendations cited. There are no medical reports, which adequately describe the relevant signs and symptoms of possible GI (gastrointestinal) disease. There is no examination of the abdomen on record. There are many possible etiologies for GI symptoms; the available reports do not provide adequate consideration of these possibilities. Empiric treatment after minimal evaluation is not indicated. Co-therapy with an NSAID is not indicated in patients other than those at high risk. No reports describe the specific risk factors present in this case. Ranitidine is not medically necessary based on the CA MTUS. In addition, medical necessity cannot be determined for unspecified compounds, and unpublished ingredients cannot be assumed to be safe or effective. Therefore, the request for Deprizine 15mg per ml oral suspension 250ml is not medically necessary.

Dicopanol (diphenhydramine) 5mg per 5ml oral suspension 150ml: 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), Mental Illness & Stress, Diphendyramine (Benadryl), and Pain, insomnia treatment.

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, Insomnia treatment, Sedative hypnotics, Diphenhydramine.

Decision rationale: The prescribing physician indicated that Dicopanol contains Diphenhydramine (Benadryl), and other proprietary ingredients. Medical necessity cannot be determined for unspecified compounds, and unpublished ingredients cannot be assumed to be safe or effective. Dicopanol is not medically necessary on this basis alone. The CA MTUS is silent regarding Diphenhydramine and the use of hypnotics other than benzodiazepines. The ODG guidelines indicate Diphenhydramine to be utilized for the treatment of insomnia, and do not recommend it. The ODG states that sedating anti-histamines are not recommended for long-term treatment of insomnia. Dicopanol is not medically necessary on this basis alone. There is no evidence of insomnia in this case. Note the Official Disability Guidelines citation above. That citation also states that antihistamines are not indicated for long term use as tolerance develops quickly, and that there are many, significant side effects. Based on these findings, the request for Dicopanol (diphenhydramine) 5mg per 5ml oral suspension 150ml is not medically necessary based on lack of a sufficient analysis of the patient's condition, the ODG citation, and lack of information provided about the ingredients.

Fanatrex (Gabapentin) 25mg per ml oral suspension 420ml: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Specific Anti-Epilepsy Drugs Page(s): 18. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Physician dispense drugs.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain; Anti-Epilepsy Drugs (AEDs) Page(s): 60, 16-21.

Decision rationale: The prescribing physician reported that Fanatrex is an oral solution, which contains Gabapentin and other proprietary ingredients including glucosamine. The treating physician has stated that it is for neuropathic pain. The CA MTUS chronic pain guidelines note Gabapentin is an anti-epilepsy drug (AEDs - also referred to as anti-convulsants), which has been shown to be effective for treatment of diabetic painful neuropathy and post-herpetic neuralgia and has been considered as a first-line treatment for neuropathic pain. The CA MTUS guidelines recommend Gabapentin for patients with spinal cord injury as a trial for chronic neuropathic pain that is associated with this condition. The CA MTUS guidelines also recommend a trial of Gabapentin for patients with fibromyalgia and patients with lumbar spinal stenosis. None of the physician reports adequately discusses the signs and symptoms diagnostic of neuropathic pain. The records do not indicate a history of seizures, fibromyalgia, lumbar spinal stenosis, diabetic neuropathy, post-herpetic neuralgia or neuropathic pain. There are no physician reports, which adequately address the specific symptomatic and functional benefit from the AEDs used to date. Note the criteria for a "good" response per the CA MTUS. The request for Fanatrex (Gabapentin) 25mg per ml oral suspension 420ml is not medically necessary based on the lack of any clear indication, and the lack of significant symptomatic and functional benefit from its use to date.

Terocin patches: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain; Topical Analgesics Page(s): 60, 111-113. Decision based on Non-MTUS Citation Drugs.com.

Decision rationale: Per Drugs.com, Terocin patches contain lidocaine and menthol and are used for the temporary relief of minor aches and muscle pains associated with arthritis, simple backache, strains, muscle soreness and stiffness. The CA MTUS recommends topical analgesics for neuropathic pain when anticonvulsants and antidepressants have been trialed and failed. The CA MTUS does not specifically address the use of menthol. The CA MTUS guidelines for topical lidocaine is it is only recommended in the form of Lidoderm patch for neuropathic pain and after trials of tri-cyclic or SNRI anti-depressants or an AED such as Gabapentin or Lyrica. Lidoderm is not recommended for low back pain or osteoarthritis, and any topical agent with lidocaine is not recommended if it is not Lidoderm. Lidocaine by itself is only indicated for post-herpetic neuralgia. The medical records do not support a diagnosis of post-herpetic neuralgia. The lidocaine in the Terocin patches is not recommended per the CA MTUS. The records do not indicate a functional benefit from the use of this medication. In addition, the request for Terocin patches does not indicate the frequency of use, or the body part for application. Therefore, the request for Terocin patches is not medically necessary.

Acupuncture for the cervical spine 3 x 6: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: Per the Acupuncture Medical Treatment guidelines, 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. Acupuncture with electrical stimulation is indicated to treat chronic pain conditions, radiating pain along a nerve pathway, muscle spasm, inflammation, scar tissue pain, and pain located in multiple sites. Acupuncture Medical Treatment guidelines recommend a trial of 3 to 6 treatments with a frequency of 1 to 3 times a week over 1 to 2 months to produce functional improvement. Acupuncture treatments may be extended if functional improvement is documented. All therapies should be focused on the goal of functional restoration rather than merely the elimination of pain and assessment of treatment efficacy is accomplished by reporting functional improvement. Functional improvement means either a clinically significant improvement in activities of daily living or a deduction in work restrictions as measured during the history and physical exam, performed and documented as part of the evaluation and management visit, and a reduction in the dependency on continued medical treatment. In this case, his work status is unclear. The records do not indicate a reduction in dependence on continued medical treatment. The records indicated he had undergone acupuncture treatment; however, the number of completed acupuncture visits and the results of those visits are not indicated. Based on these findings functional improvement is not supported. In addition, the requested acupuncture treatment 3 times a week for 6 weeks is in excess of the Acupuncture Medical Treatment guidelines recommendations. Therefore, the request of Acupuncture for the cervical spine 3 x 6 is not medically necessary.

Acupuncture for the lumbar spine 3 x 6: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: Per the Acupuncture Medical Treatment guidelines, 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. Acupuncture with electrical stimulation is indicated to treat chronic pain conditions, radiating pain along a nerve pathway, muscle spasm, inflammation, scar tissue pain, and pain located in multiple sites. Acupuncture Medical Treatment guidelines recommend a trial of 3 to 6 treatments with a frequency of 1 to 3 times a week over 1 to 2 months to produce functional improvement. Acupuncture treatments may be extended if functional improvement is documented. Acupuncture has not been found effective in the management of back pain, based on several high-quality studies, but there is anecdotal evidence of its success. All therapies should be focused on the goal of functional restoration rather than merely the elimination of pain and assessment of treatment efficacy is accomplished by reporting functional improvement. Functional improvement means either a clinically significant improvement in activities of daily living or a deduction in work restrictions as measured during the history and physical exam,

performed and documented as part of the evaluation and management visit, and a reduction in the dependency on continued medical treatment. In this case, his work status is unclear. The records do not indicate a reduction in dependence on continued medical treatment. The records indicated he had undergone acupuncture treatment; however, the number of completed acupuncture visits and the results of those visits are not indicated. Based on these findings functional improvement is not supported. In addition, the requested acupuncture treatment 3 times a week for 6 weeks is in excess of the Acupuncture Medical Treatment guidelines recommendations. Therefore, the request of Acupuncture for the lumbar spine 3 x 6 is not medically necessary.

Chiropractic manipulation for the cervical spine 3 x 6: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173, 181, Chronic Pain Treatment Guidelines Manual therapy & manipulation; functional improvement definition Page(s): 58-60, 1.

Decision rationale: The ACOEM guidelines states that cervical manipulation is a treatment option for neck pain or cervicogenic headache when used in the context of functional restoration rather than pain alone and there is insufficient evidence to support manipulation for radiculopathy. Physical manipulation of the neck and upper back is an optional treatment early in care only. Per the CA MTUS guidelines, 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. Functional improvement means either a clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam, performed and documented as part of the evaluation and management visit; and a reduction in the dependency on continued medical treatment. The quantity of chiropractic treatment prescribed 3 x 6 exceeds the 6 initial visits recommended in the CA MTUS. Therefore, the request for Chiropractic manipulation for the cervical spine 3 x 6 is not medically necessary.

Chiropractic manipulation for the lumbar spine 3 x 6: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-300, 308, Chronic Pain Treatment Guidelines Manual therapy & manipulation; functional improvement definition Page(s): 58-60, 1.

Decision rationale: The ACOEM guidelines states that manipulation is an option in the first few weeks of back pain, efficacy has not been proved for symptoms lasting longer than one month. It should be stopped if no improvement in 3-4 weeks. It is an option for radiculopathy. The focus should be on functional improvement, and return to work. Manipulation for longer than 4 weeks is not recommended. Per the CA MTUS guidelines, manual therapy &

manipulation are recommended as an option. For therapeutic care, a trial of 6 visits over 2 weeks, with evidence of objective functional improvement, for a total of up to 18 visits over 6-8 weeks. Functional improvement means either a clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam, performed and documented as part of the evaluation and management visit; and a reduction in the dependency on continued medical treatment. In this case, the prescribed chiropractic manipulation for the lumbar spine 3 x 6 is in excess of the CA MTUS recommendations for a trial of 6 visits. Therefore, the request for chiropractic manipulation for the lumbar spine 3 x 6 is not medically necessary.

Physical therapy for the cervical spine 3 x 6: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174, Chronic Pain Treatment Guidelines Physical medicine; functional restoration approach to chronic pain management Page(s): 98-99, 8.

Decision rationale: The ACOEM guidelines states that if the response to treatment with non-prescription analgesics does not adequately relieve symptoms and activity limitations, physical methods can be added. Physical methods include stretching, exercises, at home cold and heat, aerobic exercise; 1-2 visits for education, counseling, and evaluation of home exercise. All therapies are focused on the goal of functional restoration rather than merely the elimination of pain and assessment of treatment efficacy is accomplished by reporting functional improvement. Passive therapy is for the early phase of treatment. Active therapy is recommended over passive care, with transition to home therapy. The recommended quantities are: myalgia and myositis, 9-10 visits over 8 weeks; neuralgia, neuritis, and radiculitis, 8-10 visits over 4 weeks; and reflex sympathetic dystrophy (CRPS), 24 visits over 16 weeks. There is no evidence of CRPS. The quantity of physical therapy prescribed 3x6 exceeds the recommendations by the CA MTUS. In addition, there is a request for chiropractic treatment in conjunction with physical therapy, this would be redundant. Therefore, the request for physical therapy for the cervical spine 3 x 6 is not medically necessary.

Physical therapy for the lumbar spine 3 x 6: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299, Chronic Pain Treatment Guidelines Physical medicine; Functional restoration approach to chronic pain management Page(s): 98-99, 8.

Decision rationale: The ACOEM guidelines states that if the response to treatment with non-prescription analgesics does not adequately relieve symptoms and activity limitations, physical methods can be added. Physical methods include stretching, exercises, at home cold and heat,

aerobic exercise; 1-2 visits for education, counseling, and evaluation of home exercise. All therapies are focused on the goal of functional restoration rather than merely the elimination of pain and assessment of treatment efficacy is accomplished by reporting functional improvement. All therapies are focused on the goal of functional restoration rather than merely the elimination of pain and assessment of treatment efficacy is accomplished by reporting functional improvement. Passive therapy is for the early phase of treatment. Active therapy is recommended over passive care, with transition to home therapy. The recommended quantities are: myalgia and myositis, 9-10 visits over 8 weeks; neuralgia, neuritis, and radiculitis, 8-10 visits over 4 weeks; and reflex sympathetic dystrophy (CRPS), 24 visits over 16 weeks. There is no evidence of CRPS. The quantity of physical therapy prescribed 3 x 6 exceeds the recommendations by the CA MTUS. In addition, there is a request for chiropractic treatment in conjunction with physical therapy, this would be redundant. Therefore, the request for physical therapy for the lumbar spine 3 x 6 is not medically necessary.