

Case Number:	CM15-0144736		
Date Assigned:	08/31/2015	Date of Injury:	05/02/2012
Decision Date:	10/13/2015	UR Denial Date:	07/09/2015
Priority:	Standard	Application Received:	07/27/2015

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 44 year old, male who sustained a work related injury on 5-2-12. The diagnoses have included cervical strain-sprain, cervical disc syndrome without myelopathy, left shoulder supraspinatus-infraspinatus as well as tendinosis with subacromial osteoarthritis, lumbar spine strain-sprain, lumbar disc syndrome without myelopathy, lumbar radiculitis with radiculopathy to right lower extremity, and right knee effusion with possible posterior horn medial meniscus tear. Treatments have included heat therapy, topical analgesics, oral medications, massage, physical therapy, and modified duties. In the Primary Treating Physician's Initial Report dated 5-29-15, the injured worker reports pain in his neck, left shoulder, low back and right knee. He states numbness, tingling and weakness in legs and feet. He states neck pain radiates to the left side mainly the left shoulder. He states the lower back pain occasionally radiates to the right leg with numbness, tingling and weakness. On physical exam, he has tenderness to palpation of the cervical spine, paracervical, trapezius and supraspinatus muscles. Cervical spine range of motion is forward flexion at 70 degrees, extension at 80 degrees, and right and left lateral rotation and right and left lateral bending all at 35 degrees. He has tenderness to palpation of supraclavicular and acromioclavicular joints, supraspinatus and infraspinatus muscles in the left shoulder. Left shoulder range of motion is shoulder abduction to 140 degrees, forward flexion to 140 degrees, internal rotation to 50 degrees, external rotation to 70 degrees and shoulder adduction to 40 degrees. No signs of impingement. Lumbar spine is tender to touch in paraspinal muscles. Lumbar spine range of motion is forward flexion to 70 degrees and extension, right and left lateral bending and right and left lateral rotation all to 35 degrees. Straight leg raises are negative. Right knee motor strength score is 3-4 out of 5. Right knee range of motion is flexion at 70 degrees, extension to 0 degrees and lateral and medial

flexion both to 35 degrees. Grinding test, drawer test, McMurray's test, compression test and Lachman's test are all positive. Sensory and reflexes are all within normal limits. He is currently not working. The treatment plan includes chiropractic and acupuncture treatments, shockwave treatments, an MR arthrogram of the right knee, a sleep study, a functional capacity evaluation, a gait analysis test, an orthopedic consultation, durable medical equipment, a urine toxicology screen and for medicated creams.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic/physical/modality x 8 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

Decision rationale: Per the CA MTUS, Chiropractic treatments; Manual therapy & manipulation are "recommended for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range-of-motion but not beyond the anatomic range-of-motion. Low back: Recommended as an option. Therapeutic care - Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Elective/maintenance care - Not medically necessary. Recurrences/flare-ups - Need to reevaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months. Ankle & Foot: Not recommended. Carpal tunnel syndrome: Not recommended. Forearm, Wrist, & Hand: Not recommended. Knee: Not recommended. Treatment Parameters from state guidelines; a. Time to produce effect: 4 to 6 treatments. b. Frequency: 1 to 2 times per week the first 2 weeks, as indicated by the severity of the condition. Treatment may continue at 1 treatment per week for the next 6 weeks. c. Maximum duration: 8 weeks. At week 8, patients should be reevaluated. Care beyond 8 weeks may be indicated for certain chronic pain patients in whom manipulation is helpful in improving function, decreasing pain and improving quality of life. Number of Visits: Several studies of manipulation have looked at duration of treatment, and they generally showed measured improvement within the first few weeks or 3-6 visits of chiropractic treatment, although improvement tapered off after the initial sessions. If chiropractic treatment is going to be effective, there should be some outward sign of subjective or objective improvement within the first 6 visits. The request for chiropractic therapy does not specify what body parts the treatment should apply to. Since the body part(s) for treatment are not specified and there is question of radiculopathy, the requested treatment of chiropractic therapy is not medically necessary.

Acupuncture x 8 sessions: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment 2007.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment 2007.

Decision rationale: This prescription for acupuncture is evaluated in light of the CA 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". The records are not clear if the injured worker had prior acupuncture therapy, and what was the objective outcome. There was no discussion by the treating physician regarding a decrease or intolerance to pain medications. In addition, 8 visits of acupuncture exceed the MTUS recommendation. Given the MTUS recommendations for use of acupuncture, requested treatment: Acupuncture x 8 sessions is not medically necessary.

Ortho shockwave treatment x 3 sessions: 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: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter--Extracorporeal shock wave therapy (ESWT).

Decision rationale: Per ODG, Extracorporeal Shockwave Therapy (ESWT) is recommended in the treatment of burn wounds. "Shock wave therapy may work by increasing blood flow to the tissues and providing an anti-inflammatory effect." Recommended for calcifying tendinitis but not for other shoulder disorders. The request for ESWT does not specify what body part(s) are to receive the treatment. Because the injured worker does not have calcifying tendinitis, it is not recommended for any other shoulder disorders, and the site for treatment is not specified, the requested treatment of ESWT sessions is not medically necessary.

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: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter - Work conditioning, work hardening - Functional Capacity Evaluation.

Decision rationale: Per ODG, a Functional Capacity Evaluation (FCE) 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." "Guidelines for performing an FCE: Recommended prior to admission to a Work Hardening (WH) Program, with preference for assessments tailored to a specific task or job. If a worker is actively participating in determining the suitability of a particular job, the FCE is more likely to be successful. A FCE is not as effective when the referral is less collaborative and more directive. It is important to provide as much detail as possible about the potential job to the assessor. Job specific FCEs are more helpful than general assessments. The report should be accessible to all the return to work participants. Consider an FCE if1) Case management is hampered by complex issues such as: Prior unsuccessful RTW attempts. Conflicting medical

reporting on precautions and/or fitness for modified job. Injuries that require detailed exploration of a worker's abilities. 2) Timing is appropriate: Close or at MMI/all key medical reports secured. Additional/secondary conditions clarified. Do not proceed with an FCE if: The sole purpose is to determine a worker's effort or compliance. The worker has returned to work and an ergonomic assessment has not been arranged." The provider does not indicate the reason for requesting the FCE. There is insufficient documentation of the injured worker having returned to work at some point and what difficulties he found with the job. There is no documentation of his physical capability or inability to do the functions of his job. Also records do not document injured worker's return to work goals. Because of these reasons, the requested treatment of a functional capacity evaluation is not medically necessary.

Sleep study: 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: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter-- Polysomnography.

Decision rationale: Per the ODG, polysomnography (sleep studies) is "recommended after at least six months of an insomnia complaint (at least four nights a week), unresponsive to behavior intervention and sedative/sleep-promoting medications, and after psychiatric etiology has been excluded. Not recommended for the routine evaluation of transient insomnia, chronic insomnia, or insomnia associated with psychiatric disorders. This test "measures bodily functions during sleep, including brain waves, heart rate, nasal and oral breathing, sleep position, and levels of oxygen saturation. It is administered by a sleep specialist, a physician who is Board eligible or certified by the American Board of Sleep Medicine, or a pulmonologist or neurologist whose practice comprises at least 25% of sleep medicine. Criteria for Polysomnography: Polysomnograms / sleep studies are recommended for the combination of indications listed below: (1) Excessive daytime somnolence; (2) Cataplexy (muscular weakness usually brought on by excitement or emotion, virtually unique to narcolepsy); (3) Morning headache (other causes have been ruled out); (4) Intellectual deterioration (sudden, without suspicion of organic dementia); (5) Personality change (not secondary to medication, cerebral mass or known psychiatric problems); (6) Sleep-related breathing disorder or periodic limb movement disorder is suspected; (7) Insomnia complaint for at least six months (at least four nights of the week), unresponsive to behavior intervention and sedative/sleep-promoting medications and psychiatric etiology has been excluded. A sleep study for the sole complaint of snoring, without one of the above mentioned symptoms, is not recommended; (8) Unattended (unsupervised) home sleep studies for adult patients are appropriate with a home sleep study device with a minimum of 4 recording channels (including oxygen saturation, respiratory movement, airflow, and EKG or heart rate). The injured worker does not complain of any sleep related problems. Review of submitted medical records do not provide clear rationale to support the appropriateness of this test in this injured worker. The requested treatment: sleep study is not medically necessary.

MR Arthrogram of the right knee: Upheld

Claims Administrator guideline: Decision based on MTUS Knee Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Knee Complaints 2004, Section(s): Special Studies.

Decision rationale: Per the CA MTUS, ACOEM guidelines, "MRIs are superior to arthrography for both diagnosis and safety reasons." The injured worker had an MRI of the right knee done on 3-29-15. Review of submitted medical records do not provide clear rationale to support the appropriateness of this test in this injured worker. The provider's notes are not clear about any significant changes in the symptoms or clinical findings in this injured worker. The requested treatment of an MRI arthrogram of the right knee is not medically necessary.

Gait analysis test: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Uptodate.

Decision rationale: CA MTUS and ODG do not address this, therefore alternate guidelines including uptodate were reviewed. The control of gait and posture is multifactorial, and a defect at any level of control can result in a gait disorder. Gait disorders are a major cause of functional impairment and morbidity in the elderly population, affecting up to 32 percent of people age 60 years and older, and up to 62 percent or more of those who are age 80 and older. Review of the medical records do not indicate why gait analysis testing is not within the scope of the treating provider. The Requested Treatment: Gait analysis test is not medically necessary.

Ortho consultation: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, and Low Back Complaints 2004, and Knee Complaints 2004.

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/Office visits.

Decision rationale: Official Disability Guidelines (ODG) recommend office visits as determined to be medically necessary. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment. Physician may refer to other specialists if diagnosis is complex or extremely complex. Consultation is used to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability. The notes submitted by treating provider do not indicate any failure of ongoing conservative measures. Medical records are not clear about any significant change in injured worker's chronic symptoms. Considering the given guidelines, the request is not medically necessary.

Aspen summit back brace: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Work-Relatedness. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Lumbar & Thoracic (Acute & Chronic), Lumbar supports.

Decision rationale: As per MTUS-ACOEM lumbar supports have not been shown to have any lasting benefit beyond the acute phase of low back pain. Official Disability Guidelines (ODG) does not recommend it for prevention. There is strong and consistent evidence that lumbar supports were not effective in preventing neck and back pain. Lumbar supports do not prevent LBP. A systematic review on preventing episodes of back problems found strong, consistent evidence that exercise interventions are effective, and other interventions not effective, including stress management, shoe inserts, back supports, ergonomic/back education, and reduced lifting programs. This systematic review concluded that there is moderate evidence that lumbar supports are no more effective than doing nothing in preventing low-back pain. Official Disability Guidelines (ODG) Recommends it as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific LBP (very low-quality evidence, but may be a conservative option. Among home care workers with previous low back pain, adding patient-directed use of lumbar supports to a short course on healthy working methods may reduce the number of days when low back pain occurs, but not overall work absenteeism. Acute osteoporotic vertebral compression fracture management includes bracing, analgesics, and functional restoration. Medical Records of the injured worker indicate chronic low back pain. As per submitted medical records and Guidelines cited, the back brace is not medically necessary and appropriate.

Hinged knee brace: Upheld

Claims Administrator guideline: Decision based on MTUS Knee Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Knee Complaints 2004, Section(s): Activity Alteration.

Decision rationale: Per the CA MTUS, ACOEM guidelines, "A brace can be used for patellar instability, anterior cruciate ligament (ACL) tear, or medial collateral ligament (MCL) instability although its benefits may be more emotional (i.e., increasing the patient's confidence) than medical. Usually a brace is necessary only if the patient is going to be stressing the knee under load, such as climbing ladders or carrying boxes. 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." The provider does not state why the injured worker needs a knee brace. His injury is over 3 years old. There is no indication that his knee symptoms have worsened, he is being considered for surgery or that he is or will participate in a rehabilitation program. The requested treatment of a knee brace is not medically necessary.

Solace stim unit with supplies x 5 months: 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 Chronic Pain Medical Treatment 2009, Section(s): Percutaneous electrical nerve stimulation (PENS).

Decision rationale: Per the CA MTUS guidelines, Solace Stimulation Unit is a form of microcurrent electrical stimulation (MENS devices). It is "not recommended. Based on the available evidence conclusions cannot be made concerning the effect of Microcurrent Stimulation Devices (MENS) on pain management and objective health outcomes." Review of the submitted medical records do not provide clear rationale to support the appropriateness of this request in this injured worker. As this form of transcutaneous electrotherapy is not recommended and there is lack of evidence concerning pain relief from this device, the requested treatment of a Solace Stimulation unit is not medically necessary and appropriate.

Micro-Z unit with supplies: 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 Chronic Pain Medical Treatment 2009, Section(s): Electrical stimulators (E-stim).

Decision rationale: Per the CA MTUS guidelines, a Micro-Z unit is a form of Galvanic Stimulation. It is "not recommended. Considered investigational for all indications." Review of the submitted medical records do not provide clear rationale to support the appropriateness of this request in this injured worker. Since it is not recommended for use and considered an investigational treatment, the requested treatment: Micro-Z unit and supplies is not medically necessary.

Aqua relief system for the lumbar spine and knee: 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: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg Chapter, Cold/heat packs, Continuous-Flow Cryotherapy.

Decision rationale: Aqua Relief System is considered a continuous-flow cryotherapy device. ODG states Continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. This meta-analysis showed that cryotherapy has a statistically significant benefit in postoperative pain control, while no improvement in postoperative range of motion or drainage was found. As the cryotherapy apparatus is fairly inexpensive, easy to use, has a high level of patient satisfaction, and is rarely associated with adverse events, we believe that cryotherapy is justified in the postoperative management of surgery. Although the use of equipment is appropriate post-operatively, the medical records neither indicate that this injured worker had any recent surgery nor, is scheduled to have one. As such, there is no indication for use of cold unit at this time. ODG also state mechanical circulating units with pumps have not been proven to be more effective than passive hot and cold therapy. The requested treatment: Aqua relief system for the lumbar spine and knee is not medically necessary and appropriate.

Urine toxicology screening: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Drug testing. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Urine Drug Testing (UDT).

Decision rationale: The California MTUS recommends drug testing as an option, "using a urine drug screen to assess for the use or the presence of illegal drugs." ODG state; (1) UDT is recommended at the onset of treatment of a new patient who is already receiving a controlled substance or when chronic opioid management is considered. Urine drug testing is not generally recommended in acute treatment settings (i.e. when opioids are required for nociceptive pain). (2) In cases in which the patient asks for a specific drug. This is particularly the case if this drug has high abuse potential, the patient refuses other drug treatment and/or changes in scheduled drugs, or refuses generic drug substitution. (3) If the patient has a positive or "at risk" addiction screen on evaluation. This may also include evidence of a history of comorbid psychiatric disorder such as depression, anxiety, bipolar disorder, and/or personality disorder. See Opioids, screening tests for risk of addiction & misuse. (4) If aberrant behavior or misuse is suspected and/or detected. The treating provider does not provide any documentation about the need for Urine Toxicology. Guidelines are not met; therefore, the request is not medically necessary.

Flurbiprofen-Amitriptyline-Lidocaine cream 180gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: Per the CA MTUS guidelines, although recommended as an option, topical analgesics are used primarily for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Furthermore, they are largely experimental. "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." With non-steroidal anti-inflammatories (NSAIDs), "The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration." "These medications may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety." There is no documented use of Flurbiprofen in a topical analgesic cream compound. There is no available information on the use of Amitriptyline in a topical cream. Lidocaine is recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy. "Topical lidocaine, in the formulation of a dermal patch (Lidoderm) is used off-label for diabetic neuropathy. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. Guidelines indicate that any compounded product that contains at least one non-recommended drug (or drug class) is not recommended for use. Since the medications of Flurbiprofen, Amitriptyline are not recommended for topical use, the requested treatment of a medicated cream containing Flurbiprofen, Amitriptyline and Lidocaine compound is not medically necessary.