

Case Number:	CM15-0179694		
Date Assigned:	09/29/2015	Date of Injury:	09/24/2014
Decision Date:	12/10/2015	UR Denial Date:	09/04/2015
Priority:	Standard	Application Received:	09/11/2015

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California, Arizona

Certification(s)/Specialty: Physical Medicine & Rehabilitation

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The injured worker is a 47 year old female, who sustained an industrial injury on 9-24-14. The injured worker is being treated for cervical spondylosis without myelopathy, thoracic spondylosis without myelopathy, lumbar spondylosis without myelopathy, bursitis and tendinitis of shoulders, carpal tunnel syndrome, tendinitis-bursitis of right hand and aftercare for surgery of the right shoulder. (MRI) magnetic resonance imaging of right shoulder performed on 12-22-14 revealed a SLAP tear. Treatment to date has included 10 sessions of physical therapy, right shoulder arthroscopy, cortisone injections, oral medications, home exercise program and activity modifications. On 8-24-15, the injured worker complains of moderate pain in cervical spine with radiation to bilateral shoulders and back, frequent slight to moderate pain in thoracic spine, occasional slight to moderate pain in lumbar spine, constant slight to severe pain in bilateral shoulders worse on right with radiation down to right fingers, constant moderate to severe pain in right arm with a feeling dead weight, frequent moderate to severe pain in right wrist and hand with burning, tingling and aching and right fingers constant severe pain described as tingling sensation. Performing of activities of daily living causes pain and indicates difficulty sleeping. Work status is noted to be modified duties. Physical exam performed on 8-24-15 revealed tenderness to palpation of the bilateral paraspinal muscles from C2-7, bilateral suboccipital muscles and right upper shoulder muscles with decreased range of motion due to pain; tenderness to palpation of bilateral thoracic paraspinal muscles from T8-12 with painful range of motion; tenderness and spasm to palpation of bilateral lumbar paraspinal muscles from L1-S1 with painful range of motion; post-surgical scars on right shoulder with spasm and tenderness to

right rotator cuff muscles and right upper shoulder muscles with trigger point to left upper shoulder muscles and spasm and tenderness of right anterior wrist and right posterior extensor tendons with restricted range of motion. The treatment plan included 6 physical therapy visits, topical compound cream Lidocaine6% Gabapentin10% Ketoprofen 10%; multi interferential stimulator, 6 chiropractic sessions, massage to right shoulder, follow up visit, functional capacity evaluation, transcutaneous electrical nerve stimulation (TENS) unit and topical Flurbiprofen 15% Cyclobenzaprine 2% Baclofen 2% Lidocaine5%. There is no documentation of functional improvement from previous chiropractic therapy, no documentation she has reached maximum medical improvement and no significant functional improvement documented from previous transcutaneous electrical nerve stimulation (TENS) use.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical medicine right and left shoulder, right hand, lumbar and cervical spine qty: 6:
Upheld

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

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

Decision rationale: The California MTUS recommends 8-10 sessions of physical therapy for various myalgias or neuralgias. Guidelines recommend fading of treatment frequency with ultimate transition to a home exercise program. ODG Guidelines recommend six visit clinical trials of physical therapy, and close monitoring of tolerance and progress to determine if the individuals are making positive gains, no gains, or negative response to therapy. Within the records, the injured worker has had physical therapy in the past but there is no mention of significant improvements in pain using validated measures, or significant functional improvements, or significant increase in ability to participate in activities of daily living as a result of previous physical therapy. As such, ongoing therapy at this time is not medically necessary.

Chiropractic therapy, C- spine, T-spine and L-spine qty: 6: Overturned

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: California MTUS Guidelines state that chiropractic treatments are recommended for chronic pain caused by musculoskeletal conditions. Manual therapy is widely used in the treatment of musculoskeletal pain. For the low back, the MTUS recommends 6 visits over two weeks as part of a clinical trial of manual therapy, with up to 18 visits over 6-8 weeks

with evidence of objective functional improvement. A therapeutic trial of manual therapy, for six visits, would be considered reasonable in this setting. There is no apparent recent trial of manual therapy services, and as such, this request for 6 sessions of chiropractic therapy for the cervical, thoracic, and lumbar spine is appropriate and medically necessary.

Range of motion measurement: Upheld

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

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 Flexibility.

Decision rationale: According to the ODG, low back chapter on Flexibility, Range of motion testing is "Not recommended as a primary criteria, but should be a part of a routine musculoskeletal evaluation." Guidelines go on to state "Guides to the Evaluation of Permanent Impairment, 5th edition, state, "an inclinometer is the preferred device for obtaining accurate, reproducible measurements in a simple, practical and inexpensive way" (p 400). They do not recommend computerized measures of lumbar spine range of motion which can be done with inclinometers, and where the result (range of motion) is of unclear therapeutic value." Given the above, there does not appear to be a clear need for attaining range of motion testing in this particular setting. Range of motion is noted to 'monitor response.' Monitoring of response can be via clinic visit range of motion assessments on physical exam as opposed to other methods. This request as such is not medically necessary.

ADL Training: Upheld

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

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

Decision rationale: The California MTUS recommends 8-10 sessions of therapy for various myalgias or neuralgias. Guidelines recommend fading of treatment frequency with ultimate transition to a home exercise program. ADL training is typically performed through skilled occupational therapy services, and included in these services are goals for optimum ability to perform basic and instrumental activities of daily living. Within the submitted records, there is previous therapy noted but no clear significant functional response to prior therapy to warrant additional therapy for ADL training. As such, this request is not medically necessary.

Inflammation topical compound: Lidocaine 6%, Gabapentin 10%, Ketoprofen 10%) bid 180gm qty: 3: 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 MTUS guidelines, the use of topical analgesics in the treatment of chronic pain is largely experimental, and when used, is primarily recommended for the treatment of neuropathic pain when trials of first line treatments such as anti-convulsants and/or anti-depressants have failed. The guidelines go on to state that when any compounded product contains 1 medication that is not recommended, the compounded product as a whole is not recommended. This request is for topical Lidocaine, Ketoprofen, and Gabapentin. The MTUS does not support the use of topical Gabapentin, and Lidocaine is only approved for topical use as a patch for post-herpetic neuralgia. As such, the compound as a whole is rendered not medically necessary.

Muscular pain topical compound (Flurbiprofen 15%, Cyclobenzaprine 2% Baclofen 2% Lidocaine 5%) qty: 3: 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 MTUS guidelines, the use of topical analgesics in the treatment of chronic pain is largely experimental, and when used, is primarily recommended for the treatment of neuropathic pain when trials of first line treatments such as anti-convulsants and/or anti-depressants have failed. The guidelines go on to state that when any compounded product contains 1 medication that is not recommended, the compounded product as a whole is not recommended. This request is for topical Flurbiprofen, Lidocaine, Baclofen, and Cyclobenzaprine. The MTUS does not support the topical use of Cyclobenzaprine, or Baclofen. Lidocaine is only approved for topical use as a patch, for post-herpetic neuralgia. The injured worker does not maintain a diagnosis of post-herpetic neuralgia. In consideration of the above, given the guidelines, this request 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 ACOEM Guidelines, page 137-138.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Functional Capacity Evaluation.

Decision rationale: Per the ODG, functional capacity evaluations (FCE) are recommended prior to admission to work hardening programs, with preference for assessments tailored to a specific job. Not recommended as a 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. Consider an FCE if: Case management is hampered by complex issues such as prior unsuccessful return to work attempts, conflicting medical reporting on precaution and/or fitness for modified work, and injuries that require detailed exploration of the workers abilities. The criteria listed above was not clearly specified/outlined within the submitted records, and as such, this request is not medically necessary.

Multi interferential Stimulator (one month): Overturned

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): Transcutaneous electrotherapy.

Decision rationale: The CA MTUS Chronic Pain Medical Treatment Guidelines address interferential current stimulation (ICS). ICS is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments including physical methods such as therapeutic exercise. Furthermore, CA MTUS guidelines support the use of ICS as a trial for the following: 1) Pain is ineffectively controlled due to diminished effectiveness of medications. 2) Pain is ineffectively controlled with medications due to side effects. 3) History of substance abuse. 4) Significant pain from post-operative conditions limits the ability to perform exercise programs/physical therapy treatment. 5) Unresponsive to conservative measures (repositioning, heat/ice, etc.). Within the records, the IFN is noted to be for one month rental, as other attempts at pain control have failed. This will be in conjunction with medications and home exercises. As such, this request is reasonable for a one month rental, and as such, this request is medically necessary.