

Case Number:	CM15-0039001		
Date Assigned:	03/11/2015	Date of Injury:	10/12/2010
Decision Date:	04/15/2015	UR Denial Date:	02/17/2015
Priority:	Standard	Application Received:	03/02/2015

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: Neurological Surgery

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 56-year-old female, who sustained an industrial injury on 10/12/2010. She reported that she was lifting a mop bucket filled with water and noted a sharp pain to the back and re-injured herself tossing out of the trash. The injured worker was diagnosed as having cervical spine sprain/strain rule out herniated nucleus pulposus, cervical radiculopathy, right shoulder sprain/strain, rule out internal derangement, lumbar spine sprain/strain rule out herniated nucleus pulposus, and lumbar radiculopathy. Treatment to date has included magnetic resonance imaging of the right shoulder, magnetic resonance imaging of the lumbar spine, magnetic resonance imaging of the cervical spine, x-rays, physical therapy, acupuncture, and medication regimen. In a progress note dated 01/26/2015 the treating provider reports complaints of constant, moderate to severe, burning, radicular neck pain and muscle spasms with a pain rating of a seven to nine out of ten with associated symptoms of numbness and tingling of the bilateral upper extremities. The injured worker has complaints of constant, moderate to severe burning to the right shoulder radiating to the arm to the fingers with associated symptoms of muscle spasms with a pain rating of a seven out of ten. The injured worker also has complaints of constant, moderate to severe burning radicular back pain with muscle spasms with a pain rating of a seven to nine out of ten, associated symptoms of numbness, and tingling to the bilateral lower extremities. The treating physician requested a course of acupuncture and physical therapy to the lumbar spine, cervical spine, and right shoulder, and localized intense neurostimulation therapy to the lumbar spine, but did not indicate the specific reason for these requested treatments. The treating physician also requested Terocin patch for pain relief.

IMR ISSUES, DECISIONS AND RATIONALES

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

Acupuncture, 3 times weekly, lumbar spine, per 01/02/15 order quantity: 18.00: Upheld
Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 1 Prevention, Chapter 12 Low Back Complaints Page(s): 9, 300, Acupuncture Treatment Guidelines.

Decision rationale: California MTUS guidelines note acupuncture would be recommended for time to produce functional improvement which would be expected in 3 to 6 treatments at a frequency of 1 to 3 times a per week. The optimum duration would be expected in 1 to 2 months. The California MTUS note that acupuncture has not been found effective in the management of back pain. The requested treatment does not comply with these guidelines. Thus the requested treatment: Acupuncture, three times weekly, lumbar spine, per 01/02/15 order quantity: 18.00 is not medically necessary and appropriate.

Physical therapy, 3 times weekly, lumbar spine, per 01/26/15 order quantity: 18.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back (updated 11/18/14) Physical therapy (PT), ODG Physical Therapy Guidelines, sprains and strains of neck, ODG Shoulder (updated 10/31/14), ODG Low Back (updated 01/30/15).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

Decision rationale: The California MTUS guidelines note that physical modalities such as massage, diathermy, cutaneous laser treatment, ultrasound, transcutaneous electrical stimulation, percutaneous electrical nerve stimulation and biofeedback have no proven efficacy in treatment low back symptoms. Aerobic exercise along with specific low back exercises for range of motion and strengthening are recommended. 1-2 visits for education, counseling and evaluation of home exercise for range of motion and strengthening are recommended. Thus the requested treatment: Physical therapy, 3 times weekly, lumbar spine, per 01/26/15 order quantity: 18.00 is not medically necessary and appropriate.

Localized intense neurostimulation therapy lumbar spine, per 01/26/15 order quantity: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & Upper Back (updated 11/18/14) Physical therapy (PT), ODG Physical Therapy Guidelines,

sprains and strains of neck, ODG Shoulder (updated 10/31/14), ODG Low Back (updated 01/30/15).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrical Therapy Page(s): 114, 117, 118.

Decision rationale: The California MTUS guidelines do not recommend transcutaneous electrical stimulation (TENS) as a primary treatment modality. The guidelines do not recommend inferential current stimulation as isolated intervention. The guidelines do not recommend H-wave stimulation as an isolated intervention. The guidelines note there is no evidence H-wave is more effective as an initial treatment when compared to TENS. Thus the requested treatment: Localized intense neuromodulation therapy lumbar spine, per 01/26/15 order quantity: 1.0 is not medically necessary and appropriate.

Terocin patches, lumbar spine, per 1/26/15 order quantity: 1.00: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 111-112.

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

Decision rationale: The California MTUS guidelines recommend topical analgesics as a option when trials of antidepressants and anticonvulsants have failed. The documentation does not show this to be evident. Moreover, the guidelines note the use of compounded agents requires knowledge of the specific effect of each agent and how it will be useful for the specific therapeutic goal required. The documentation does not display evidence of this knowledge. The requested treatment: Terocin patches, lumbar spine, per 1/26/15 order quantity: 1.00 is not medically necessary and appropriate.