

Case Number:	CM15-0089281		
Date Assigned:	05/13/2015	Date of Injury:	10/22/1999
Decision Date:	10/13/2015	UR Denial Date:	04/09/2015
Priority:	Standard	Application Received:	05/08/2015

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

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 54 year old female, who sustained an industrial injury on 10/22/1999 reported neck pain, upper back and left arm pain. On provider visit dated 05/06/2015 the injured worker has reported neck pain, and headaches. She was noted to have numbness and tingling in her right hand, fourth and fifth digits and was noted to have difficulty with depression as well. On examination of the bilateral upper extremities, sensation to pinprick was decreased on the right fourth and fifth digits. Reflexes of the both upper extremities were nonreactive. The diagnoses have included chronic neck pain with degenerative disc disease and chronic tension headache. Rule out right cervical radiculopathy in the view of numbness in the fourth and fifth digits. Treatment to date has included medication, acupuncture, physical and massage therapy. The provider requested functional capacity evaluation, lumbar epidural steroid injection L4-5, L5-S1, Massage therapy session Qty 8, independent gym program with pool exercise for 1 year, acupuncture session Qty 8, CBT biofeedback sessions Qty 24, Sonata 10mg #30, Lidoderm 5 patch #30, Aspercreme #1 tube, Thermacare for neck #10 boxes, Metaxalone 800mg #90, and EMG/NCS upper extremities.

IMR ISSUES, DECISIONS AND RATIONALES

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

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 (ODG); Fitness for Duty.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness for Duty Chapter, Functional Capacity Evaluation and Other Medical Treatment Guidelines ACOEM, Chapter 7, p. 137-138.

Decision rationale: Regarding request for functional capacity evaluation, ACOEM Practice Guidelines state that there is not good evidence that functional capacity evaluations are correlated with a lower frequency of health complaints or injuries. ODG states that functional capacity evaluations are recommended prior to admission to a work hardening program. The criteria for the use of a functional capacity evaluation includes case management being hampered by complex issues such as prior unsuccessful return to work attempts, conflicting medical reporting on precautions and/or fitness for modified job, or injuries that require detailed explanation of a worker's abilities. Additionally, guidelines recommend that the patient be close to or at maximum medical improvement with all key medical reports secured and additional/secondary conditions clarified. Within the documentation available for review, there is no indication that there has been prior unsuccessful return to work attempts, conflicting medical reporting, or injuries that would require detailed exploration. Given this, the currently requested functional capacity evaluation is not medically necessary.

Lumbar Epidural Steroid Injection L4-5, L5-S1: 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): Epidural steroid injections (ESIs).

Decision rationale: Regarding the request for lumbar epidural steroid injection, Chronic Pain Medical Treatment Guidelines state that epidural injections are recommended as an option for treatment of radicular pain, defined as pain in dermatomal distribution with corroborative findings of radiculopathy, after failure of conservative treatment. Guidelines recommend that no more than one interlaminar level or two transforaminal levels should be injected in one session. Within the documentation available for review, there are no recent subjective complaints or objective examination findings supporting a diagnosis of radiculopathy. Additionally, there are no imaging or electrodiagnostic studies corroborating the diagnosis of radiculopathy. Given this, the currently requested lumbar epidural steroid injection is not medically necessary.

Massage Therapy Sessions QTY 8: 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): Massage therapy.

Decision rationale: Regarding the request for massage therapy, Chronic Pain Medical Treatment Guidelines state the massage therapy is recommended as an option. They go on to state the treatment should be an adjunct to other recommended treatment (e.g. exercise), and it should be limited to 4 to 6 visits in most cases. Within the documentation available for review, it is unclear as to the number of massage therapy visits the patient has previously undergone. Furthermore, there is no documentation of objective functional improvement from the therapy sessions already authorized. Additionally, it is unclear exactly what objective treatment goals are hoping to be addressed with the currently requested massage therapy. In the absence of clarity regarding those issues, the currently requested massage therapy is not medically necessary.

Independent Gym Program with Pool Exercises for 1 year: 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); Low Back, Lumbar & Thoracic (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Exercise. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Gym Memberships.

Decision rationale: Regarding request for gym membership, Chronic Pain Medical Treatment Guidelines state that exercise is recommended. They go on to state that there is no sufficient evidence to support the recommendation of any particular exercise regimen over any other exercise regimen. ODG states the gym memberships are not recommended as a medical prescription unless a documented home exercise program with periodic assessment and revision has not been effective and there is a need for equipment. Plus, treatment needs to be monitored and administered by medical professionals. With unsupervised programs, there is no information flow back to the provider, so he or she can make changes in the prescription, and there may be a risk of further injury to the patient. Within the documentation available for review, there is no indication that the patient has failed a home exercise program with periodic assessment and revision. Additionally, there is no indication that the patient has been trained on the use of gym equipment, or that the physician is overseeing the gym exercise program. In the absence of such documentation, the currently requested gym membership is not medically necessary.

Acupuncture Sessions QTY 8: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment 2007.

Decision rationale: Regarding the request for acupuncture, California MTUS does support the use of acupuncture for chronic pain. Acupuncture is recommended to be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Additional use is supported when there is functional improvement documented, which is defined as "either a clinically significant improvement in activities of daily living or a reduction in work restrictions and a reduction in the dependency on continued medical treatment." A trial of up to 6 sessions is recommended, with up to 24 total sessions supported when there is ongoing evidence of functional improvement. In the case of this particular request (for 8 sessions), the patient has had prior acupuncture sessions with partial improvement of headaches. However, there is no documentation of specific functional improvement and what remaining deficits are expected to be treated with additional acupuncture sessions. Therefore, this request is not medically necessary.

CBT Biofeedback Sessions QTY 24: 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); Psychotherapy Guidelines, Mental Illness & Stress.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Biofeedback, Psychological evaluations, Psychological treatment. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Biofeedback Topic.

Decision rationale: In the case of this injured worker, there has been documentation of significant depression, insomnia, and psychological distress associated with the work-related injury. However, the Official Disability Guidelines recommend a trial of 3-4 sessions of biofeedback in conjunction with cognitive behavior therapy. Therefore, the patient has had prior sessions of cognitive behavior therapy without documented symptomatic or functional improvement. As such, the currently requested CBT with biofeedback is not medically necessary.

Sonata 10mg #30: 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), Pain (Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter & Mental Illness and Stress Chapter, Insomnia Topics.

Decision rationale: Regarding the request for Sonata, California MTUS guidelines are silent regarding the use of sedative hypnotic agents. ODG recommends the short-term use (usually two to six weeks) of pharmacological agents only after careful evaluation of potential causes of sleep disturbance. They go on to state the failure of sleep disturbances to resolve in 7 to 10 days, may indicate a psychiatric or medical illness. Within the documentation available for review, there is

documentation of sonata helping the patient with her insomnia. However, there are no discussion regarding how frequently the insomnia complaints occur or how long they have been occurring, and no statement indicating what behavioral treatments have been attempted for the condition of insomnia. Finally, there is no indication that Sonata is being used for short-term use as recommended by guidelines. In the absence of such documentation, the currently requested Sonata is not medically necessary.

Lidoderm 5 patch #30: 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): Lidoderm (lidocaine patch), Topical Analgesics.

Decision rationale: Regarding request for topical Lidoderm, Chronic Pain Medical Treatment Guidelines recommend the use of topical lidocaine for localized peripheral pain after there has been evidence of a trial of the first line therapy such as tricyclic antidepressants, SNRIs, or antiepileptic drugs. Within the documentation available for review, there is no indication that the patient has failed first-line therapy recommendations. Additionally, there is no documentation of objective functional improvement as a result of the currently prescribed Lidoderm. As such, the currently requested Lidoderm is not medically necessary.

Aspercreme #1 tube: 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: Regarding the request for topical Aspercreme (containing Trolamine salicylate), the guidelines states that topical NSAIDs are indicated for "Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine. Neuropathic pain: Not recommended as there is no evidence to support use." Therefore, this request is not medically necessary.

Thermacare for neck #10 boxes: Upheld

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

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Initial Care. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Cold/Heat Packs.

Decision rationale: Regarding the request for Thermacare heat patch, ACOEM Practice Guidelines state that various modalities such as heating have insufficient testing to determine their effectiveness, but they may have some value in the short term if used in conjunction with the program of functional restoration. ODG states that heat/cold packs are recommended as an option for acute pain. Within the documentation available for review, and there is no indication that the patient has acute pain. Additionally, it is unclear what program of functional restoration the patient is currently participating in which would be used alongside the currently requested heating patch. Furthermore, it is unclear why Thermacare has been prescribed as opposed to a economic heating modality such as a heating pad. Given this, the currently request is not medically necessary.

Metaxalone 800mg #90: 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): Muscle relaxants (for pain).

Decision rationale: Regarding the request for Metaxalone, Chronic Pain Medical Treatment Guidelines support the use of non-sedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Guidelines go on to state that Metaxalone specifically is recommended orally for the treatment of spasticity and muscle spasm related to multiple sclerosis and spinal cord injuries. Within the documentation available for review, it does not appear that the medication is used for muscle spasm but is used to help the patient sleep. Additionally, it does not appear that this medication is being prescribed for the short-term treatment, as recommended by guidelines. Given this, the currently requested Metaxalone is not medically necessary.

EMG/NCS upper extremities: Overturned

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Neck and Upper Back - Cervical and Thoracic (Cute & Chronic).

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck Chapter, Electrodiagnostic Studies, Electromyography, Nerve Conduction Studies.

Decision rationale: Regarding the request for EMG and nerve conduction studies of the upper extremity, ACOEM Practice Guidelines state that the electromyography and nerve conduction velocities including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. Within the documentation available for review, there are recent physical examinations findings of reduced

sensation of right 4th and 5th digits, reduced strength of bilateral hands, and non-reactive reflexes of bilateral upper extremities. As such, the current request for EMG and nerve conduction study of bilateral upper extremities is appropriate to explore the cause of neurological defects. Therefore, this request is medically necessary.