

Case Number:	CM15-0091231		
Date Assigned:	05/18/2015	Date of Injury:	11/22/2013
Decision Date:	09/24/2015	UR Denial Date:	04/15/2015
Priority:	Standard	Application Received:	05/12/2015

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: 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 57 year old female, who sustained an industrial injury on 11/22/13. She reported initial complaints of neck, low back, bilateral upper extremities; bilateral shoulders. The injured worker was diagnosed as having cervical sprain/strain; cervical disc displacement; cervical disc syndrome; lumbar spine strain; right acromioclavicular joint strain; right shoulder strain; carpal tunnel syndrome; depression; anxiety; right eye pain; insomnia; palmar dermatitis. Treatment to date has included physical therapy; acupuncture; TENS unit; shockwave therapy; infrared therapy; urine dug screening; back brace; wrist brace; medications. Diagnostics included multiposition MRI right and left shoulder (12/29/14); MRI right wrist with Flex-Ext (12/29/14). Currently, the PR-2 notes dated 3/26/15 indicated the injured worker complains of Cervical and lumbar spine and right shoulder pain of 10/10. She also complains of left shoulder, right wrist and left wrist pain levels 10/10. She also suffers from depression and anxiety. A physical examination id documented with cervical spine noted with painful range of motion. There is tenderness to palpation of the bilateral upper trapezii, cervical paravertebral muscles and spinous processes with muscle spasm and Soto-Hall as positive. The lumbar spine reveals tenderness to palpation of the lumbar paravertebral muscles and spinous processes with muscle spasm and positive Kemp's testing. Her bilateral shoulders reveal tenderness to palpation of the acromioclavicular joints and anterior shoulders. Her bilateral wrist indicates FROM, no swelling, Reverse Phalen's Test as positive, sensation is intact with 5/5/ muscle strength. The provider has requested : Orthopedic surgeon consultation; pain management consultation; Physio therapy 1x every 6 weeks; Acupuncture 1 x 6; cervical traction system rental; lumbar traction system rental;

chiropractic treatment 1 x 6; Extracorporeal Shock Wave Therapy (ESWT) Treatments (duration & frequency unknown); Urine Analysis Testing; (VSNCT) Voltage- Actuated Sensory Nerve Conduction Threshold; Capsaicin 0.025%; Flurbiprofen 15%; Gabapentin 10%; Menthol 2%; Camphor 2% 180grams; Gabapentin 15%; Amitriptyline 4%; Dextromethorphan 10% 180grams.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar Traction System, rental: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Low Back Chapter.

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

Decision rationale: According to the MTUS, traction has not been proved effective for lasting relief in treating low back pain. Because evidence is insufficient to support using vertebral axial decompression for treating low back injuries, it is not recommended. At present, based on the records provided, and the evidence-based guideline review, the request is non-certified. Lumbar Traction System, rental is not medically necessary.

Cervical Traction System, rental: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Neck & Upper Back Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic) Chapter, Traction.

Decision rationale: The Official Disability Guidelines recommend home cervical patient-controlled traction (using a seated over-the-door device or a supine device, which may be preferred due to greater forces), for patients with radicular symptoms, in conjunction with a home exercise program. Not recommend institutionally based powered traction devices. Several studies have demonstrated that home cervical traction can provide symptomatic relief in over 80% of patients with mild to moderately severe (Grade 3) cervical spinal syndromes with radiculopathy. There is no documentation of mild to moderately severe (Grade 3) cervical spinal syndromes with radiculopathy. Cervical Traction System, rental is not medically necessary.

Pain Management Consultation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, page127 and the Official Disability Guidelines (ODG); Evaluation & Management, Low Back Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 7, Independent Medical Examinations and Consultations, page 132.

Decision rationale: According to the MTUS, a referral request should specify the concerns to be addressed in the independent or expert assessment, including the relevant medical and non-medical issues, diagnosis, causal relationship, prognosis, temporary or permanent impairment, workability, clinical management, and treatment options. The medical record lacks sufficient documentation and does not support a referral request. Pain Management Consultation is not medically necessary.

Capsaicin 0.025%; Flurbiprofen 15%; Gabapentin 10%; Menthol 2%; Camphor 2% 180grams: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Applications Page(s): 111-113.

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

Decision rationale: According to the MTUS, there is little to no research to support the use of many of these Compounded Topical Analgesics. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Flurbiprofen topical is not supported by the MTUS. Capsaicin 0.025%; Flurbiprofen 15%; Gabapentin 10%; Menthol 2%; Camphor 2% 180grams is not medically necessary.

Gabapentin 15%; Amitriptyline 4%; Dextromethorphan 10% 180grams: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Applications Page(s): 111-113.

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

Decision rationale: According to the MTUS, there is little to no research to support the use of many of these compounded topical analgesics. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Gabapentin is not recommended. There is no peer-reviewed literature to support use. Gabapentin 15%; Amitriptyline 4%; Dextromethorphan 10% 180grams is not medically necessary.

Physio Therapy (6-sessions, once every 6 weeks): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 98 and 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Low Back, Neck and Upper Back and Shoulder Chapter.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58.

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines state that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Continued physical therapy is predicated upon demonstration of a functional improvement. There is no documentation of objective functional improvement. In addition, California Labor Code Section 4604.5(c) (1) states that an employee shall be entitled to no more than 24 chiropractic, 24 occupational therapy, and 24 physical therapy visits per industrial injury. The medical record indicates that the patient has previously undergone 24 sessions of physical therapy. During the previous physical therapy sessions, the patient should have been taught exercises which are to be continued at home as directed by MTUS. Additional physical therapy is not medically necessary.

Extracorporeal Shock Wave Therapy (ESWT) Treatments (duration & frequency unknown): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Peer Review Literature on Extracorporeal Shock Wave Therapy.

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 - Lumbar & Thoracic (Acute & Chronic) Chapter, Shock wave therapy.

Decision rationale: The Official Disability Guidelines do not recommend shockwave therapy. The available evidence does not support the effectiveness of ultrasound or shock wave for treating LBP. In the absence of such evidence, the clinical use of these forms of treatment is not justified and should be discouraged. Limited evidence exists regarding extracorporeal shock wave therapy (ESWT) in reducing pain and improving function. While it appears to be safe, there is disagreement as to its efficacy. Insufficient high quality scientific evidence exists to determine clearly the effectiveness of this therapy. Extracorporeal Shock Wave Therapy (ESWT) Treatments (duration & frequency unknown) is not medically necessary.

Orthopedic Surgeon Consultation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, page 127 and Official Disability Guidelines (ODG), Low Back Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 7, Independent Medical Examinations and Consultations, page 132.

Decision rationale: According to available documentation the patient does not meet the criteria for a surgical consultation. The patient has not failed conservative treatment and there is no evidence of progressive and significant neurologic symptomology involving the cervical or lumbar spine. Therefore, the request for 1 referral to orthopedic surgeon for consultation is recommended non-certified. Orthopedic Surgeon Consultation is not medically necessary.

(VSNCT) Voltage- Actuated Sensory Nerve Conduction Threshold: 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); Neck Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic) Chapter, Current perception threshold (CPT) testing.

Decision rationale: According to the Official Disability Guidelines, (VSNCT) Voltage-Actuated Sensory Nerve Conduction Threshold, also called current perception threshold (CPT) testing is not recommended. There are no clinical studies demonstrating that quantitative tests of sensation improve the management and clinical outcomes of patients over standard qualitative methods of sensory testing. (VSNCT) Voltage- Actuated Sensory Nerve Conduction Threshold is not medically necessary.

Acupuncture (6-sessions, once a week for 6-weeks): Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The Acupuncture Medical Treatment Guidelines state that the initial authorization for acupuncture is for 3-6 treatments. Authorization for more than 6 treatments would be predicated upon documentation of functional improvement. There is no documentation in the medical record that the patient has had functional improvement with the trial of visits of acupuncture previously authorized. Acupuncture (6-sessions, once a week for 6-weeks) is not medically necessary.

Urine Analysis Testing: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use, Steps to take before a Therapeutic Trial of Opioids, On-going Management Page(s): 43 and 78.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug Testing Page(s): 43.

Decision rationale: The MTUS recommends using a urine drug screen to assess for the use or the presence of illegal drugs, a step to take before a therapeutic trial of opioids, to aid in the ongoing management of opioids, or to detect dependence and addiction. There is no documentation in the medical record that a urine drug screen was to be used for any of the above indications. Urine Analysis Testing is not medically necessary.

Chiropractic Treatment (6-sessions, once a week for 6-weeks): Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 298 and 299, Chronic Pain Treatment Guidelines Manipulation for low back Page(s): 58.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58-60.

Decision rationale: The request is for 6 visits of chiropractic. The Chronic Pain Medical Treatment Guidelines allow for an initial 4-6 visits after which time there should be documented functional improvement prior to authorizing more visits. The request for 6 chiropractic visits is in accordance with the MTUS as appropriate to establish whether the treatment is effective. I am reversing the previous utilization review decision. Chiropractic Treatment (6-sessions, once a week for 6-weeks) is medically necessary.