
Notice of Independent Medical Review Determination

Dated: 12/11/2013

[REDACTED]

[REDACTED]

Employee: [REDACTED]
Claim Number: [REDACTED]
Date of UR Decision: 8/15/2013
Date of Injury: 1/20/2011
IMR Application Received: 8/26/2013
MAXIMUS Case Number: CM13-0016717

- 1) MAXIMUS Federal Services, Inc. has determined the request for **240 gram compound (Capsaicin 0.025%/Flurbiprofen 30%/Methyl Salicylate 4%) refills is not medically necessary and appropriate.**
- 2) MAXIMUS Federal Services, Inc. has determined the request for **240 gram compound (Flurbiprofen 20%/Tramadol 20%) refills is not medically necessary and appropriate.**
- 3) MAXIMUS Federal Services, Inc. has determined the request for **thirty Medorx patch refills is not medically necessary and appropriate.**
- 4) MAXIMUS Federal Services, Inc. has determined the request for **chiropractic treatments two times a week for two weeks then one time a week for two weeks is not medically necessary and appropriate.**
- 5) MAXIMUS Federal Services, Inc. has determined the request for **acupuncture treatments is not medically necessary and appropriate.**
- 6) MAXIMUS Federal Services, Inc. has determined the request for **functional capacity evaluation is not medically necessary and appropriate.**
- 7) MAXIMUS Federal Services, Inc. has determined the request for **Neurostimulator TENS/EMS unit for one month trial is not medically necessary and appropriate.**

- 8) MAXIMUS Federal Services, Inc. has determined the request for **NCV upper extremity is not medically necessary and appropriate.**
- 9) MAXIMUS Federal Services, Inc. has determined the request for **EMG upper extremity is not medically necessary and appropriate.**
- 10)MAXIMUS Federal Services, Inc. has determined the request for **ESWT is not medically necessary and appropriate.**
- 11)MAXIMUS Federal Services, Inc. has determined the request for **MRI cervical spine is not medically necessary and appropriate.**
- 12)MAXIMUS Federal Services, Inc. has determined the request for **MRI left shoulder is not medically necessary and appropriate.**
- 13)MAXIMUS Federal Services, Inc. has determined the request for **MRA is not medically necessary and appropriate.**
- 14)MAXIMUS Federal Services, Inc. has determined the request for **LINT is not medically necessary and appropriate.**

INDEPENDENT MEDICAL REVIEW DECISION AND RATIONALE

An application for Independent Medical Review was filed on 8/26/2013 disputing the Utilization Review Denial dated 8/15/2013. A Notice of Assignment and Request for Information was provided to the above parties on 10/11/2013. A decision has been made for each of the treatment and/or services that were in dispute:

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14)MAXIMUS Federal Services, Inc. has determined the request for **LINT is not medically necessary and appropriate.**

Medical Qualifications of the Expert Reviewer:

The independent Medical Doctor who made the decision has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Occupational Medicine, and is licensed to practice in California. 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 treatments and/or services at issue.

Expert Reviewer Case Summary:

The applicant is a represented healthcare industry self insurance program employee who has filed a claim for chronic neck, low back, and shoulder pain reportedly associated with an industrial injury of January 20, 2011.

Thus far, the applicant has been treated with the following: Analgesic medications; topical agents; attorney representation; psychological counseling; prior epidural steroid injections on September 29, 2011 and August 4, 2011; an MRI of the left shoulder of August 15, 2013, notable for low-grade tendinosis and arthrosis of uncertain clinical significance; an MRI of the cervical spine of August 13, 2013, notable for multilevel disk dissection; prior electrodiagnostic testing of May 26, 2011, notable for bilateral carpal tunnel syndrome and negative for any radiculopathy; unspecified amounts of prior manipulative therapy; unspecified amounts of acupuncture over the life of the claim; and extensive periods of time off of work, on total temporary disability.

In a utilization review report of August 15, 2013, the claims administrator denied request for several topical compounds denied a request for manipulative therapy, denied request for acupuncture, denied a functional capacity evaluation, and denied numerous MRI studies and electrodiagnostic tests.

A handwritten note of August 23, 2013 is notable for comment that the applicant is reportedly better with medications. Nevertheless, the applicant remains off of work, on total temporary disability. Manipulation, acupuncture, and extracorporeal shockwave therapy are sought.

An earlier note of July 22, 2013 is notable for comments that the applicant is alleging pain secondary to cumulative trauma. She also reports depression and anxiety. She is status post three epidural steroid injections and has also received physical therapy. She reports ongoing neck, shoulder, and mid back pain, it is stated. She is in moderate distress. She exhibits tenderness and limited range of motion about the spine and shoulder. Topical compounds; extracorporeal shockwave therapy, localized intense neurotransmitter therapy, and electrical stimulation are sought, in conjunction with numerous topical compounds. The applicant remains off of work, on total temporary disability.

Documents Reviewed for Determination:

The following relevant documents received from the interested parties and the documents provided with the application were reviewed and considered. These documents included:

- Application of Independent Medical Review
- Utilization Review Determination
- Medical Records from Claims Administrator
- Medical Treatment Utilization Schedule (MTUS)

1) Regarding the request for 240 gram compound (Capsaicin 0.025%/Flurbiprofen 30%/Methyl Salicylate 4%) refills:

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, page 111, which is part of the MTUS.

The Expert Reviewer based its decision on the Initial Approaches to Treatment (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 3), Table 3-1, Oral Pharmaceuticals, and the Chronic Pain Medical Treatment Guidelines, page 111, which are part of MTUS.

Rationale for the Decision:

As noted in the MTUS-adopted ACOEM guidelines in chapter 3, oral pharmaceuticals are the first line palliative measure. In this case, there is no evidence of intolerance to and/or failure of the first line oral analgesics so as to make a case for usage of topical agents and/or topical compounds, which, per ACOEM table 3-1 are “not recommended.” It is noted that the unfavorable ACOEM recommendation is echoed by that of the MTUS Chronic Pain Medical Treatment Guidelines, which, on page 111, deemed topical analgesics “largely experimental.” **The request for 240 gram compound (Capsaicin 0.025%/Flurbiprofen 30%/Methyl Salicylate 4%) refills is not medically necessary and appropriate.**

2) Regarding the request for 240 gram compound (Flurbiprofen 20%/Tramadol 20%) refills:

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, page 111, which is part of the MTUS.

The Expert Reviewer based its decision on the Initial Approaches to Treatment (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 3), Table 3-1, Oral Pharmaceuticals, and the Chronic Pain Medical Treatment Guidelines, page 111, which are part of MTUS.

Rationale for the Decision:

Again, as suggested by ACOEM in chapter 3, oral pharmaceuticals are the first line palliative measure. There is no evidence of intolerance to and/or failure of first line oral analgesics so as to make a case for usage of topical agents and/or topical compounds, which, per ACOEM table 3-1, are “not recommended” and, per page 111 of the MTUS Chronic Pain Medical Treatment, are “largely experimental.” **The request for 240 gram compound (Flurbiprofen 20%/Tramadol 20%) refills is not medically necessary and appropriate.**

3) Regarding the request for thirty Medorx patch refills:

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, pages 105 and 111-113, which are part of the MTUS.

The Expert Reviewer based its decision on the Initial Approaches to Treatment (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 3), Table 3-1, Oral Pharmaceuticals, and the Chronic Pain Medical Treatment Guidelines, page 111, which are part of MTUS.

Rationale for the Decision:

The employee does not appear to have tried and/or failed first line oral analgesics, which, per ACOEM in chapter 3, are a first line palliative method. There is, consequently, no support for usage of topical agents and/or topical compounds, which are per ACOEM table 3-1 “not recommended” and are, per page 111 of the MTUS Chronic Pain Medical Treatment Guidelines “largely experimental.” **The request for thirty Medorx patch refills is not medically necessary and appropriate.**

4) Regarding the request for chiropractic treatments two times a week for two weeks then one time a week for two weeks:

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, Manual therapy & manipulation, pages 58-59, which are part of the MTUS.

The Expert Reviewer based its decision on the Chronic Pain Medical Treatment Guidelines (2009), Manual therapy & manipulation, pages 58-59, which are part of the MTUS.

Rationale for the Decision:

It appears that the employee underwent unspecified amounts of prior chiropractic manipulative therapy between June and November 2011. As noted on pages 58 and 59 of the MTUS Chronic Pain Medical Treatment Guidelines, the primary criteria for continuation of manual therapy is evidence of successful return to work. In this case, however, the employee has had prior unspecified amounts of

manipulative therapy over the life of claim and failed to return to work. The fact that the employee has failed to return to work despite having completed unspecified amounts of prior manipulation does not make a case for extension of manipulative therapy. **The request for chiropractic treatments two times a week for two weeks then one time a week for two weeks is not medically necessary and appropriate.**

5) Regarding the request for acupuncture treatments:

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Acupuncture Medical Treatment Guidelines, which is part of MTUS.

The Expert Reviewer based its decision on the Acupuncture Medical Treatment Guidelines (2009), which is part of MTUS.

Rationale for the Decision:

It is suggested that the employee previously underwent acupuncture between June and November 2011. As noted in MTUS 9792.24.1d, acupuncture may be extended if there is evidence of functional improvement as defined in MTUS 9792.20f. In this case, however, there is no evidence of functional improvement as defined in section 9792.20f. The fact that the employee remains off of work, several years removed from the date of injury, and continues to pursue numerous analgesic, adjuvant, and topical agents implies the lack of functional improvement as defined in section 9792.20f. **The request for acupuncture treatments is not medically necessary and appropriate.**

6) Regarding the request for functional capacity evaluation:

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Official Disability Guidelines (ODG), Treatment Index: Ankle & Foot, which is not part of MTUS.

The Expert Reviewer based its decision on the Chronic Pain Medical Treatment Guidelines (2009), page 125, which is part of the MTUS, and the Initial Approaches to Treatment (ACOEM Practice Guidelines, 2nd Edition (2004), pages 137-138, which are not part of the MTUS.

Rationale for the Decision:

Page 125 of the MTUS Chronic Pain Medical Treatment Guidelines indicates that functional capacity evaluations can be employed as a precursor to enrolment in a work hardening program. In this case, however, there is no evidence that the employee is a candidate for work hardening program. It is further noted that the ACOEM guidelines in chapter 7, do not strongly endorse functional capacity evaluations, noting that they are highly simplified, are not necessarily an accurate characterization or depiction of what an applicant can or cannot do in the workplace, and should not be used as a substitute for clinical judgment. In this

case, the fact that the employee remains off of work, on total temporary disability, subsequently removed from the date of surgery, implies that she is not necessarily a good candidate for FCE testing. **The request for functional capacity evaluation is not medically necessary and appropriate**

7) Regarding the request for Neurostimulator TENS/EMS unit for one month trial:

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Chronic Pain Medical Treatment Guidelines, pages 114-115, which are part of MTUS.

The Expert Reviewer based its decision on the Chronic Pain Medical Treatment Guidelines (2009), page 121, which is part of MTUS.

Rationale for the Decision:

One of the modalities in the device, electrical muscle stimulation, represents a form of neuromuscular electrical stimulation (NMES), which, per page 121 of the MTUS Chronic Pain Medical Treatment Guidelines, is only endorsed in the post stroke rehabilitative context. It is not endorsed in the chronic pain context present here. **The request for Neurostimulator TENS/EMS unit for one month trial is not medically necessary and appropriate.**

8) Regarding the request for NCV upper extremity:

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Neck and Upper Back Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 8, page 178, which is part of MTUS.

The Expert Reviewer based its decision on the Forearm, Wrist, and Hand Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11), Diagnostic Criteria section, which is part of MTUS.

Rationale for the Decision:

As noted in the MTUS-adopted ACOEM guidelines in chapter 11, electrodiagnostic testing can be repeated later in a treatment course if initial electrodiagnostic testing is negative. In this case, the employee has had prior electrodiagnostic testing in 2011, which apparently established a diagnosis of bilateral carpal tunnel syndrome. It is not clearly stated why repeat testing is being sought. **The request for NCV upper extremity is not medically necessary and appropriate.**

9) Regarding the request for EMG upper extremity:

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Neck and Upper Back Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 8, page 178, which is part of MTUS.

The Expert Reviewer based its decision on the Forearm, Wrist, and Hand Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 11), Diagnostic Criteria section, which is part of MTUS.

Rationale for the Decision:

As noted in the MTUS-adopted ACOEM guidelines in chapter 11, electrodiagnostic testing can be repeated at a later point in the treatment course if initially negative. In this case, however, the employee has had prior electrodiagnostic testing in 2011, which is positive for establishing a diagnosis of bilateral carpal tunnel syndrome. Repeat testing is therefore redundant. **The request for EMG upper extremity is not medically necessary and appropriate.**

10) Regarding the request for extracorporeal shockwave therapy (ESWT):

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Elbow Disorders Chapter (ACOEM Practice Guidelines, 2nd Edition (Revised 2007), Chapter 10) page 29, which is part of the MTUS.

The Expert Reviewer based its decision on the Shoulder Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 9), Initial Care section, which is part of MTUS.

Rationale for the Decision:

While the MTUS-adopted ACOEM guidelines in chapter 9 do weakly endorse extracorporeal shockwave therapy in those individuals with radiographically confirmed calcifying tendonitis of the shoulder, in this case, the employee has had MRI imaging on August 13, 2013, which fails to establish a diagnosis of calcifying tendonitis/tendinosis of the shoulder for which extracorporeal shockwave therapy would, indeed, be indicated. **The request for ESWT is not medically necessary and appropriate.**

11) Regarding the request for MRI cervical spine:

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Neck and Upper Back Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 8), pages 177-178, which are part of the MTUS.

The Expert Reviewer based its decision on the Neck and Upper Back Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 8), Table 8-8, which is part of MTUS.

Rationale for the Decision:

As noted in the MTUS-adopted ACOEM guidelines in chapter 8, table 8-8, MRI imaging can be employed to validate the diagnosis of nerve root compromise, based on clear history and physical exam findings, in preparation for an invasive procedure. In this case, however, there is no clear evidence of radiculopathy, nor is there evidence that the employee would consider surgery or other interventional remedies where it offered to her. Therefore, the original utilization review decision is upheld. **The request for MRI cervical spine is not medically necessary and appropriate.**

12) Regarding the request for MRI left shoulder:

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the ACOEM, Shoulder Chapter, Special Studies and Diagnostic and Treatment Considerations section, which is part of MTUS.

The Expert Reviewer based its decision on the Shoulder Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 9), Table 9-6, which is part of MTUS.

Rationale for the Decision:

As noted in the MTUS-adopted ACOEM guidelines in chapter 9, table 9-6, MRI imaging can be employed preoperatively to evaluate full-thickness and/or partial thickness rotator cuff tears. In this case, however, the employee had prior MRI imaging in May 2011, also only notable for arthrosis and tendinosis of uncertain clinical significance. There was no clear evidence of a change or significant deterioration of clinical picture for which repeat MRI imaging was indicated. Furthermore, there is no evidence that the applicant would act on the test results and/or consider surgical remedy were it offered to her. **The request for MRI left shoulder is not medically necessary and appropriate.**

13) Regarding the request for magnetic resonance arthrography (MRA):

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator based its decision on the Shoulder Complaints Chapter (ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 9) pages 207-208 and Chronic Pain Medical Treatment Guidelines, Section, which are part of MTUS.

The Expert Reviewer found that no section of the MTUS was applicable. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Expert Reviewer

based his/her decision on the American College of Occupational and Environmental Medicine (ACOEM) Guidelines, 3rd Edition, Shoulder Chapter, Diagnostic and Treatment Considerations section.

Rationale for the Decision:

As noted in the third edition ACOEM guidelines, MR arthrography is selectively recommended to evaluate labral tears, partial thickness rotator cuff tears and/or subscapularis tears. MRA imaging is not, however, routinely recommended. In this case, there is no clearly voiced suspicion or statement of diagnoses or differential diagnoses for which MRA imaging would have been indicated. The attending provider does not state that he suspects a partial thickness rotator cuff tear, subscapularis tear, labral tear, etc. **The request for MRA is not medically necessary and appropriate.**

14) Regarding the request for localized intense neurostimulation therapy (LINT):

The Medical Treatment Guidelines Relied Upon by the Expert Reviewer to Make His/Her Decision

The Claims Administrator did not cite any evidence based criteria for its decision.

The Expert Reviewer based its decision on Chronic Pain Medical Treatment Guidelines, page 97, which is part of MTUS.

Rationale for the Decision:

As noted in page 97 of the MTUS Chronic Pain Medical Treatment Guidelines, PENS is not recommended as a primary treatment modality, but can be considered as an adjunct to program of functional restoration after other nonsurgical treatments, including exercises, medications, physical therapy, AND TENS units have been tried and/or failed. In this case, there is no evidence that each and all of the aforementioned above modalities were tried and/or failed. **The request for LINT is not medically necessary and appropriate.**

Effect of the Decision:

The determination of MAXIMUS Federal Services and its physician reviewer is deemed to be the final determination of the Administrative Director, Division of Workers' Compensation. With respect to the medical necessity of the treatment in dispute, this determination is binding on all parties.

In accordance with California Labor Code Section 4610.6(h), a determination of the administrative director may be reviewed only if a verified appeal is filed with the appeals board for hearing and served on all interested parties within 30 days of the date of mailing of the determination to the employee or the employer. The determination of the administrative director shall be presumed to be correct and shall be set aside only upon proof by clear and convincing evidence of one or more of the grounds for appeal listed in Labor Code Section 4610.6(h)(1) through (5).

Sincerely,

Paul Manchester, MD, MPH
Medical Director

cc: Department of Industrial Relations
Division of Workers' Compensation
1515 Clay Street, 18th Floor
Oakland, CA 94612

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Disclaimer: MAXIMUS is providing an independent review service under contract with the California Department of Industrial Relations. MAXIMUS is not engaged in the practice of law or medicine. Decisions about the use or nonuse of health care services and treatments are the sole responsibility of the patient and the patient's physician. MAXIMUS is not liable for any consequences arising from these decisions.