MAXIMUS Federal Services

Case Number:	CM14-0001759		
Date Assigned:	04/04/2014	Date of Injury:	04/02/2011
Decision Date:	05/23/2014	UR Denial Date:	12/27/2013
Priority:	Standard	Application Received:	01/06/2014

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. The expert 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 disputed items/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 46-year-old female with date of injury 04/02/2011. The medical document associated with the request for authorization: a primary treating physician's progress report, dated 11/20/2013, lists subjective complaints as sharp low back pain that radiates to her right knee when walking. The patient also states she has numbness, tingling and weakness in her right leg. Objective findings: examination of the lumbar spine revealed tenderness to palpation of the lumbar paraspinal muscles. She was positive for myospasm. She also had decreased strength and range of motion of the right leg. The diagnoses are: lumbar spine intervertebral disc syndrome with radiation, status post gastric bypass, and status post L5-S1 lumbosacral fusion. There is documentation that the patient has 6 visits of physical therapy authorized, but no documentation of functional improvement. The medical reports provided for review document that the patient has been taking the following medications for at least as far back as 5/28/2013. The medications are: 1. Capsaicin 25% 240g; 2. Flurbiprofen 15%; 3. Tramadol 15%; 4. Menthol 2%; 5. Camphor 2%; 6. Gabapentin 10%; 7. Lidocaine 5%; and no Sig given for the above medications.

IMR ISSUES, DECISIONS AND RATIONALES

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

SIX (6) SESSIONS OF PHYSIOTHERAPY: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 58.

Decision rationale: According to the MTUS guidelines, therapeutic physical therapy for the low back is recommended as an option with authorization for a trial of 6 visits over 2 weeks, with evidence of objective functional improvement, prior to authorizing more treatments with a total of up to 18 visits over 6-8 weeks. In this case, there is no documentation of objective functional improvement. Due to lack of clinical support for the medical necessity for additional physical therapy, the request for six (6) sessions for physiotherapy is not medically necessary.

ONE LINT (LOCALIZED INTENSE NEUROSTIMULATOR THERAPY) FOR THE LUMBAR SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), National guidelines Clearinghouse.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: For all conditions or injuries not addressed in the MTUS, the authorized treatment and diagnostic services in the initial management and subsequent treatment for presenting complaints shall be in accordance with other scientifically and evidence-based medical treatment guidelines that are nationally recognized by the medical community pursuant to section 9792.25(b). The request for one localized intense neuro-stimulation therapy (LINT) for the lumbar spine is experimental and not recognized as a scientifically and evidence-based medical treatment covered in a nationally recognized treatment guideline. Thus, the request is not medically necessary and appropriate.

ONE INITIAL PROLOTHERAPY CONSULTATION FOR THE LUMBAR SPINE: 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: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99-100.

Decision rationale: According to the MTUS guidelines, prolotherapy describes a procedure for strengthening lax ligaments by injecting proliferating agents/sclerosing solutions directly into torn or stretched ligaments or tendons or into a joint or adjacent structures to create scar tissue in an effort to stabilize a joint. Prolotherapy is not recommended by the MTUS. As such, the request for Prolotherapy is not medically necessary.

ONE 120G SUPPLY OF CAPSAICIN 0.25%/ FLURBIPROFEN 10%/ TRAMADOL 10%/ MENTHOL 2%/ CAMPHOR 2%: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

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

Decision rationale: According to the MTUS guidelines, there is little to no research to support the use of many of these compounded topical analgesics. The MTUS states that "any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." Tramadol is not recommended as a topical analgesic. As such, the request for one 120g supply of capsaicin 0.25%/flurbiprofen 10%/Tramadol 10%/menthol 2%/camphor 2% is not medically necessary.

ONE 240G SUPPLY OF GABAPENTIN 10%/ LIDOCAINE 5%/ TRAMADOL 15%: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

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

Decision rationale: According to the MTUS guidelines, there is little to no research to support the use of many of these compounded topical analgesics. The MTUS states that "any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." Gagapentin is not recommended as a topical analgesic. As such, the request for one 240g supply of gabapentin 10%/lidocaine 5%/tramadol 15% is not medically necessary.

ONE NCV STUDY OF THE LOWER EXTREMITY: 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: 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), Lumbar EMG/NCS.

Decision rationale: According to the Official Disability Guidelines (ODG), nerve conduction studies are not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. The ODG indicates that neurological testing procedures have limited overall diagnostic accuracy in detecting disc herniation with suspected radiculopathy. As such, the request for one nerve conduction velocity (NCV) study of the lower extremity is not medically necessary.

ONE EMG STUDY OF THE LOWER EXTREMITY: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

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), Lumbar EMG/NCS.

Decision rationale: According to the Official Disability Guidelines (ODG), electromyography (EMG) is recommended as an option and may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG is not necessary if radiculopathy is already clinically obvious. In this case, the patient had a set of EMG/NCS (nerve conduction study) in September 2011 which were negative for lumbar radiculopathy. According to records, there has been little or no change in the patient's leg symptoms since the study; consequently, there is no reason to believe that conditions have changed and a radiculopathy is now present. Thus the request for one EMG study of the lower extremity is not medically necessary.

ONE DNA TESTING: 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: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 42.

Decision rationale: There is currently no evidence-based, peer-reviewed guidelines recommending genetic testing to determine hereditary predisposition to the addiction of narcotics. There is currently no evidence-based guideline supporting that the knowledge of a patient's genetic propensity to addiction would change or guide the treatment in any way. A similar situation using cytokine DNA testing for pain is referenced in the MTUS Chronic Pain guidelines and is not recommended. As such, the request for one DNA testing is not medically necessary.

ONE VITAL WRAP FOR THE LUMBAR SPINE: Upheld

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

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), Cold Packs.

Decision rationale: The Vital Wrap system is an all in one system that combines heating, cooling and compression. The Official Disability Guidelines (ODG) states that at-home local

application of cold packs in first few days of acute complaint; thereafter, applications of heat packs or cold packs. Continuous low-level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. The evidence for the application of cold treatment to low-back pain is more limited than heat therapy, with only three poor quality studies located that support its use, but studies confirm that it may be a low risk low cost option. There is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful for pain reduction and return to normal function. The ODG cites no evidence that rotating heat and cold to the lumbar is effective in treating chronic lumbar pain. The request for one vital wrap is not medically necessary.