

Case Number:	CM14-0130613		
Date Assigned:	09/26/2014	Date of Injury:	10/23/2012
Decision Date:	11/17/2014	UR Denial Date:	07/08/2014
Priority:	Standard	Application Received:	08/15/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine 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 50 year old male with an injury date of 10/23/12. Based on the 05/12/14 progress report provided by [REDACTED] the patient complains of low back pain rated 8-9/10 that radiates down his lower extremities. The patient underwent low back surgery March 2013. Per operative report dated 06/25/14, he underwent therapeutic caudal epidural. Physical examination to the lumbar spine revealed facet tenderness at bilateral L4-L5 and L5-S1. Range of motion is reduced on flexion, extension and lateral bending. Straight leg raise test is positive bilaterally. Past treatment included physical therapy, chiropractic, acupuncture and surgical evaluations. Current medications include Vicodin and Ultram. MRI impression of the lumbar spine dated 01/30/14 showed laminectomy defects noted at L5-S1 level correlate with surgical history and L5-S1: Diffuse disc protrusion without effacement of the thecal sac. Disc material and facet hypertrophy causing bilateral neuroforaminal narrowing that effaces the left and right L5 exiting nerve roots, more so on left side than right. Grade I retrolisthesis of L4 over L5 and L5 over S1 noted. Present scan when compared with previous scan of December 12, 2013 shows neural foraminal narrowing at L5 S1 levels on both sides in the current scan not appreciated previously"Diagnosis 05/12/14 are lumbar radiculopathy, status post low back surgery and lumbar facet arthropathy. Per progress report dated 06/04/14 by [REDACTED] patient has a TENS unit. The following are check marked under Treatment Plan: chiropractic/physiotherapy/physical therapy twice a week for six weeks, acupuncture once a week for six weeks, Neuro Diagnostic Medical, Voltage-actuated sensory nerve conduction threshold (VSNCT) to the Lumbar Spine, 180 gm- Capsaicin 0.025%, Flurbiprofen 20%, Tramadol 15%, Menthol 2%, Camphor 2%, 180 gm- Gabapentin 10%, Lidocaine 5%, Tramadol 15%, Extracorporeal shockwave therapy to the Lumbar Spine, Neurosurgeon/Ortho Lumbar

Spine, Pain Management Follow-Up, DNA Testing, and Toxicology Testing. [REDACTED] is the requesting provider, and he provided treatment reports from 01/30/14 - 06/25/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic Treatment: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Treatments Page(s): 58-59.

Decision rationale: The patient complains of low back pain rated 8-9/10 that radiates down his lower extremities. The request is for Chiropractic Treatment. The patient is status post L5-S1 laminectomy, confirmed by MRI dated 01/30/14, and has undergone therapeutic caudal epidural procedure 06/24/14. Per progress report dated 05/12/14 past treatments included physical therapy, chiropractic, acupuncture and surgical evaluations. With regards to Chiropractic, MTUS under its chronic pain section has the following regarding manual therapy and treatments: (page 58, 59) Manual therapy & manipulation: Low back: "Recommended as an option. Therapeutic care - Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks." Per progress report dated 06/04/14, the provider requests 12 chiropractic visits, though not stated specifically in request. In review of reports, there is no mention of total number of previous visits or evidence of functional improvement documented. The provider has not stated reason for request, either. Furthermore, the request would exceed what is allowed by MTUS without pertinent information. Therefore, this request is not medically necessary.

Physiotherapy: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98, 99.

Decision rationale: The request is for Physiotherapy. The patient is status post L5-S1 laminectomy confirmed by MRI dated 01/30/14, and has undergone therapeutic caudal epidural procedure 06/24/14. Per progress report dated 05/12/14 past treatments included physical therapy, chiropractic, acupuncture and surgical evaluations. Patient is past post-operative time period. MTUS pages 98, 99 have the following: "Physical Medicine: recommended as indicated below. Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." MTUS guidelines pages 98, 99 states that for "Myalgia and myositis, 9-10 visits are recommended over 8 weeks. For Neuralgia, neuritis, and radiculitis, 8-10 visits are recommended." Per progress report dated 06/04/14, the provider

requests 12 physical therapy visits, though not specifically stated in request. In review of reports, there is no mention of total number of previous visits or evidence of functional improvement documented. The provider has not documented reason for request either. Furthermore, the request would exceed what is allowed by MTUS without pertinent information. Therefore, this request is not medically necessary.

Voltage Actuated Sensory Nerve Conduction: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back (updated 7/3/14)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG). I was not able to locate a reference in MTUS/ACOEM topics, MTUS/Chronic Pain Guidelines, or Official Disability Guidelines - TWC guidelines related to the issue at hand.

Decision rationale: The request is for Voltage Actuated Sensory Nerve Conduction. The patient is status post L5-S1 laminectomy confirmed by MRI dated 01/30/14, and has undergone therapeutic caudal epidural procedure 06/24/14. Per progress report dated 05/12/14 past treatments included physical therapy, chiropractic, acupuncture and surgical evaluations. Voltage actuated sensory nerve conduction is a type of quantitative perception sensory testing, or Current Perception Threshold testing which is not supported by Official Disability Guidelines. Therefore, this request is not medically necessary.

Acupuncture: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The request is for Acupuncture. He is status post L5-S1 laminectomy confirmed by MRI dated 01/30/14, and has undergone therapeutic caudal epidural procedure 06/24/14. Per progress report dated 05/12/14 past treatments included physical therapy, chiropractic, acupuncture and surgical evaluations. When reading MTUS for acupuncture, prior response to therapy is not pre-requisite to a trial of acupuncture. MTUS allows for a trial of acupuncture up to 6 sessions and more if functional improvement is demonstrated. Per progress report dated 06/04/14, the provider requests 6 acupuncture visits, though not stated in request. In review of reports, there is no mention of total number of previous visits or evidence of functional improvement documented. The provider has not documented reason for request either. Furthermore, the request would exceed what is allowed by MTUS without pertinent information. Therefore, this request is not medically necessary.

Compound creams: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

Decision rationale: The request is for Compound Creams. He is status post L5-S1 laminectomy confirmed by MRI dated 01/30/14, and has undergone therapeutic caudal epidural procedure 06/24/14. Per progress report dated 05/12/14 past treatments included physical therapy, chiropractic, acupuncture and surgical evaluations. Per progress report 06/04/14, requested compound cream include the following:- 180 gm- Capsaicin 0.025%, Flurbiprofen 20%, Tramadol 15%, Menthol 2%, Camphor 2%- 180 gm- Gabapentin 10%, Lidocaine 5%, Tramadol 15% The MTUS has the following regarding topical creams (page 111, chronic pain section): "Topical Analgesics: Recommended as an option as indicated below. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Non-steroidal anti-inflammatory agents (NSAIDs): The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Gabapentin: Not recommended." The requested compounded creams contain Flurbiprofen and Gabapentin, which are not indicated by guidelines. Therefore, this request is not medically necessary.

Neuro consult: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Occupational Medicine Practice Guidelines, 2nd Edition, 2004 page 127

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation - I was not able to locate a reference in MTUS/ACOEM topics, MTUS/Chronic Pain Guidelines, or ODG-TWC guidelines related to the issue at hand

Decision rationale: The patient complains of low back pain rated 8-9/10 that radiates down his lower extremities. The request is for Neuro Consult. He is status post L5-S1 laminectomy confirmed by MRI dated 01/30/14, and has undergone therapeutic caudal epidural procedure 06/24/14. Per progress report dated 05/12/14 past treatments included physical therapy, chiropractic, acupuncture and surgical evaluations. In review of reports, the closest mention to the request is "Neuro Diagnostic Medical," found under the 'Treatment Plan' section of progress report dated 06/04/14. This is not a misspelled request, since "Neurosurgeon/Ortho L/S" is also requested on same page of said progress report. The provider has not documented what "Neuro Diagnostic Medical" does, or why patient would need a "Neuro Consult." The request is unclear and determination cannot be made based on guidelines. Therefore, this request is not medically necessary.

Pain Management follow-up: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back - (updated 7/3/2014) Office Visits

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Independent medical examination and consultations, Chapter 7 page 127

Decision rationale: The patient complains of low back pain rated 8-9/10 that radiates down his lower extremities. The request is for Pain Management follow-up. He is status post L5-S1 laminectomy confirmed by MRI dated 01/30/14, and has undergone therapeutic caudal epidural procedure 06/24/14. Per progress report dated 05/12/14 past treatments included physical therapy, chiropractic, acupuncture and surgical evaluations. ACOEM Practice Guidelines, 2nd Edition (2004), page 127 has the following: "The occupational health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise." Therefore, this request is medically necessary.

DNA testing: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cytokine DNA Testing for pain Page(s): 42.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG-TWC, Pain chapter, Genetic testing for potential opioid abuse

Decision rationale: The request is for DNA testing. He is status post L5-S1 laminectomy confirmed by MRI dated 01/30/14, and has undergone therapeutic caudal epidural procedure 06/24/14. Per progress report dated 05/12/14 past treatments included physical therapy, chiropractic, acupuncture and surgical evaluations. MTUS/ACOEM does not discuss genetic testing, however ODG-TWC states, "Pain chapter on Genetic testing for potential opioid abuse: Not recommended. While there appears to be a strong genetic component to addictive behavior, current research is experimental in terms of testing for this. "In review of reports, the only mention pertaining to the request is "DNA Testing" under the Treatment Plan section of progress report dated 06/04/14. The provider has not documented the reason the patient needs this test performed. Moreover, the request is not supported by Official Disability Guidelines. Therefore, this request is not medically necessary.

Toxicology testing: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 77-80 and 94.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioid Management Page(s): 77. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Chronic Pain Chapter, Urine Drug Screen

Decision rationale: The request is for toxicology testing. He is status post L5-S1 laminectomy confirmed by MRI dated 01/30/14, and has undergone therapeutic caudal epidural procedure 06/24/14. Per progress report dated 05/12/14 past treatments included physical therapy, chiropractic, acupuncture and surgical evaluations. MTUS page 77, under opioid management: (j) "Consider the use of a urine drug screen to assess for the use or the presence of illegal drugs." Official Disability Guidelines has the following criteria regarding Urine Drug Screen: "Patients at "low risk" of addiction/aberrant behavior should be tested within six months of initiation of therapy and on a yearly basis thereafter. There is no reason to perform confirmatory testing unless the test is inappropriate or there are unexpected results. If required, confirmatory testing should be for the questioned drugs only. Patients at "moderate risk" for addiction/aberrant behavior are recommended for point-of-contact screening 2 to 3 times a year with confirmatory testing for inappropriate or unexplained results. Patients at "high risk" of adverse outcomes may require testing as often as once per month. This category generally includes individuals with active substance abuse disorders. "In review of reports, the only mention pertaining to the request is "Toxicology Testing" under the Treatment Plan section of progress report dated 06/04/14. The provider may have intended to request a "urine drug screen" for the management of opioid medications, since patient is Vicodin and Ultram. Review of the reports does not show that urine drug screens are used excessively. Official Disability Guidelines and MTUS do support periodic urine toxicology for opiate management. Therefore, this request is medically necessary.

ESWT L/S and VSNCT L/S: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back (updated 7/3/2014) - Shockwave Therapy

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Lumbar chapter, Shock wave therapy

Decision rationale: The patient complains of low back pain rated 8-9/10 that radiates down his lower extremities. The request is for ESWT L/S and VSNCT L/S. He is status post L5-S1 laminectomy confirmed by MRI dated 01/30/14, and has undergone therapeutic caudal epidural procedure 06/24/14. Per progress report dated 05/12/14 past treatments included physical therapy, chiropractic, acupuncture and surgical evaluations. Official Disability Guidelines states under Shock Wave therapy, "Not recommended. 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. (Seco, 2011)" Given the lack of the guidelines support for this treatment, this request is not medically necessary.