

<b>Case Number:</b>	CM13-0043765		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	10/03/2012
<b>Decision Date:</b>	06/03/2014	<b>UR Denial Date:</b>	10/09/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/25/2013

### 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 Orthopedic Surgery, and is licensed to practice in Texas. 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 58 year old female injured on 10/03/12 due to an undisclosed mechanism of injury. Neither the specific injury sustained nor the initial treatments rendered were addressed in the clinical documentation submitted for review. The patient complained of cervical spine, right shoulder, and lumbar spine pain with psychological overlay. The patient received extensive treatment with multiple physicians including psychiatry and psychological treatment, physical therapy, aquatic therapy, acupuncture, and medication management. The patient reported therapy modalities and medication provided pain improvement however she remained symptomatic. Clinical documentation indicated the patient reporting left shoulder and arm pain, mid back pain, low back pain, hip pain, and sacrum/coccyx pain. Physical exam revealed restricted lumbar and cervical range of motion, bilateral upper and lower extremity neurological examination showed 5/5 strength, except right knee extension was noted 4/5, normal sensation except diminished over L5 nerve root distribution. Medications included metformin, glipizide, lisinopril, simvastatin, robaxen, norco, meloxicam, ativan, lamictal, trazadone, and ambien.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**AQUATIC THERAPY, 8 SESSIONS (2X4), LUMBAR SPINE, CERVICAL SPINE, BILATERAL SHOULDERS AND COCCYX AREA: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic therapy..

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22.

**Decision rationale:** As noted on page 22 of the MTUS Chronic Pain Guidelines, aquatic therapy is recommended as an optional form of exercise therapy, where available, as an alternative to land-based physical therapy. Aquatic therapy (including swimming) can minimize the effects of gravity, so it is specifically recommended where reduced weight bearing is desirable, for example extreme obesity. There is no indication in the documentation that the patient is severely obese. Additionally, the documentation does not indicate the number of previous therapy sessions that she has attended and exceptional factors that would support the need for therapy that exceeds the MTUS Chronic Pain Guidelines' recommendations either in duration of treatment or number of visits. As such, the request is not medically necessary and appropriate.

**URINE ANALYSIS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids.

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

**Decision rationale:** As noted on page 43 of the MTUS Chronic Pain Guidelines, urine drug screens are recommended as an option to assess for the use or the presence of illegal drugs. However, with the decline of the requested opioid medication, ongoing urine drug screening is no longer necessary. As such, the request for urine analysis is not recommended as medically necessary.

**TRAMADOL (ER) EXTENDED RELEASE 150MG, 2 TIMES A DAY:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 77.

**Decision rationale:** As noted on page 77 of the MTUS Chronic Pain Guidelines, patients must demonstrate functional improvement in addition to appropriate documentation of ongoing pain relief to warrant the continued use of narcotic medications. There is no clear documentation regarding the functional benefits or any substantial functional improvement obtained with the continued use of narcotic medications. As the clinical documentation provided for review does not support an appropriate evaluation for the continued use of narcotics or establish the efficacy of narcotics, the request is not medically necessary and appropriate.

**LIDODERM PATCHES:** 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): 111-113.

**Decision rationale:** As noted on page 111 of the MTUS Chronic Pain Guidelines, topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no indication in the documentation that these types of medications have been trialed and/or failed. Further research is needed to recommend Lidoderm treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. Therefore the request is not medically necessary and appropriate.

**GABAKETOLIDO CREAM, 2 TO 3 TIMES A DAY: 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): 111-113.

**Decision rationale:** As noted on page 111 of the MTUS Chronic Pain Guidelines, the safety and efficacy of compounded medications has not been established through rigorous clinical trials. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no indication in the documentation that these types of medications have been trialed and/or failed. This compound contains Gabapentin and Ketamine, which have not been approved for transdermal use. In addition, there is no evidence within the medical records provided for review that substantiates the necessity of a transdermal versus oral route of administration. Therefore this compound is not medically necessary and appropriate.

**CAPSAICIN CREAM, 2 TO 3 TIMES A DAY: 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): 111-113.

**Decision rationale:** As noted on page 111 of the MTUS Chronic Pain Guidelines, the safety and efficacy of compounded medications has not been established through rigorous clinical trials. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no indication in the medical records provided for review that these types of medications have been trialed and/or failed. Therefore this request is not medically necessary and appropriate.

## **MRI OF THE CERVICAL SPINE: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Cervical and Thoracic Spine Disorders Chapter.

**Decision rationale:** As noted in the ACOEM Cervical and Thoracic Spine Disorders chapter, an MRI study is not recommended for the evaluation of patients with non-specific chronic cervicothoracic pain. An MRI may be considered if the purpose is to rule out non-injury-related diagnoses in select patients, such as possible neoplasia, infection, or other neurological illnesses, based on the presence of symptoms or findings that suggest these diagnoses. The clinical documentation does not indicate objective findings that would substantiate the necessity of MRI of the cervical spine. Sensation and motor strength are intact to the upper extremities. As such, the request is not medically necessary and appropriate.

## **MRI OF THE COCCYX: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: AMERICAN COLLEGE OF OCCUPATIONAL AND ENVIRONMENTAL MEDICINE (ACOEM) 2ND EDITION, (2004), CERVICAL AND THORACIC SPINE DISORDERS, ONLINE VERSION.

**Decision rationale:** As noted in the ACOEM Cervical and Thoracic Spine Disorders chapter, an MRI is not recommended for the evaluation of patients with non-specific chronic lumbosacral pain. An MRI may be considered if the purpose is to rule out non-injury-related diagnoses in select patients, such as possible neoplasia, infection, or other neurological illnesses, based on the presence of symptoms or findings that suggest these diagnoses. The clinical documentation does not indicate objective findings that would substantiate the necessity of MRI of the coccyx. Sensation and motor strength are intact lower extremities minus the L5 distribution. As such, the request is not medically necessary and appropriate.

## **EMG/NCV OF THE UPPER EXTREMITIES: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

**Decision rationale:** As noted in the ACOEM Guidelines, electrodiagnostic studies are recommended to evaluate non-specific hand, wrist, or forearm pain for patients with paresthesias or other neurological symptoms. The clinical documentation indicates that the patient is

neurovascularly intact to the bilateral upper extremities with no sensation deficits noted. As such, the request is not medically necessary and appropriate.

**LUMBOSCRAL BRACE, LOS PURCHASE:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**Decision rationale:** As noted in the Low Back Disorders Chapter of the ACOEM Guidelines, Lumbar supports are not recommended for treatment of low back pain. Additionally, lumbar supports are not recommended for prevention of low back pain. As such, the request is not medically necessary and appropriate.