

<b>Case Number:</b>	CM13-0063671		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	07/21/2013
<b>Decision Date:</b>	08/07/2014	<b>UR Denial Date:</b>	11/12/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/10/2013

### 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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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:

Patient is a 39-year-old male who has submitted a claim for low back contusion, coccyx sprain / strain, and buttocks contusion associated with an industrial injury date of 07/21/2013. Medical records from 2013 were reviewed. Patient complained of left-sided low back pain described as sharp of moderate-to-severe intensity, radiating to the left lower extremity. Patient likewise reported intermittent left shoulder pain aggravated by movement. Patient denied weakness, numbness, and tingling sensation at left shoulder. There was no weakness of bilateral lower extremities. Physical examination of the left shoulder showed tenderness and restricted range of motion. Strength of left shoulder muscles was normal. Apprehension sign was negative, as well as drop arm sign. Impingement testing for integrity of the left rotator cuff was positive. Physical examination of the thoracolumbar spine showed tenderness and restricted range of motion. Heel / toe ambulation was performed without difficulty. Straight leg raise was positive. Sensation was intact. Motor strength was normal. X-ray of the left shoulder from 07/24/2013 was normal. MRI of the left shoulder, dated 11/21/2013, demonstrated acromioclavicular osteoarthritis, supraspinatus tendinitis, infraspinatus tendinitis, and bicipital tenosynovitis. MRI of the thoracic spine, dated 11/21/2013, was unremarkable. MRI of the lumbar spine, dated 11/21/2013, showed 1-2 mm posterior disc bulge at L5-S1 level without evidence of canal stenosis or neural foraminal narrowing. Treatment to date has included six sessions of physical therapy, and medications such as Naproxen, Tramadol, and Orphenadrine. Utilization review from 11/12/2013 denied the requests for left shoulder MRI and lumbar spine MRI because patient was already authorized to undergo the procedures on September 2013; denied thoracic spine MRI because there were no neurologic deficits; denied EMG/NCV of bilateral lower extremities because physical examination did not show motor, reflex or sensory deficits; denied Cyclobenzaprine 7.5 mg because patient was initially prescribed Orphenadrine and there was no documented treatment response; denied naproxen 550 mg because there was no discussion

concerning functional gains; denied Omeprazole 20 mg because there were no gastrointestinal complaints; and denied physical therapy 2 x 4 because there were no subjective or functional improvements attributed to previous therapy sessions.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **LEFT SHOULDER MRI: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208-209.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208.

**Decision rationale:** Page 208 of CA MTUS ACOEM supports ordering of imaging studies for: emergence of a red flag; physiologic evidence of tissue insult or neurologic dysfunction; failure to progress in a strengthening program intended to avoid surgery; and clarification of the anatomy prior to an invasive procedure. In this case, patient complained of intermittent left shoulder pain aggravated by movement. Patient denied weakness, numbness, and tingling sensation. Physical examination of the left shoulder showed tenderness, positive impingement test, and restricted range of motion. Strength was normal. Apprehension sign was negative, as well as drop arm sign. However, previous utilization review cited that authorization for left shoulder MRI was given on September 2013. Of note, patient underwent MRI on 11/21/2013 demonstrating acromioclavicular osteoarthritis, supraspinatus / infraspinatus tendinitis, and bicipital tenosynovitis. There is no clear indication for a repeat MRI at this time. There was no worsening of subjective or objective complaints that would warrant such. The medical necessity was not established. Therefore, the request for MRI of the left shoulder is not medically necessary.

#### **THORACIC SPINE MRI: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, MRI.

**Decision rationale:** As stated on pages 303-304 of the ACOEM Practice Guidelines referenced by CA MTUS, imaging of the thoracic spine is recommended in patients with red flag diagnoses where plain film radiographs are negative; unequivocal objective findings that identify specific nerve compromise on the neurologic examination, failure to respond to treatment, and consideration for surgery. In addition, Official Disability Guidelines recommends MRI for uncomplicated back pain, with radiculopathy, after at least 1 month of conservative therapy. In this case, patient complained of low back pain, however, there was no documentation concerning pain complaints at the upper back area. There was no available comprehensive examination pertaining to the thoracic spine. Tenderness was the only pertinent objective finding recorded for the thoracic spine. There was no evidence of new injury or trauma to the spine, which may warrant diagnostic imaging. Therefore, request for MRI of the thoracic spine

is not medically necessary.

**LUMBAR SPINE-MRI: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Section, MRI.

**Decision rationale:** As stated on pages 303-304 of the ACOEM Practice Guidelines referenced by CA MTUS, imaging of the lumbar spine is recommended in patients with red flag diagnoses where plain film radiographs are negative; unequivocal objective findings that identify specific nerve compromise, failure to respond to treatment, and consideration for surgery. In addition, Official Disability Guidelines recommends MRI for the lumbar spine for uncomplicated low back pain, with radiculopathy, after at least 1 month of conservative therapy, sooner if severe, or progressive neurologic deficit. In this case, patient complained of left-sided low back pain radiating to the left lower extremity. Patient denied weakness of both legs. Physical examination showed tenderness and restricted range of motion. Heel / toe ambulation was performed without difficulty. Straight leg raise was positive. Sensation and motor strength were normal. However, previous utilization review cited that authorization for MRI was given on September 2013. Of note, patient underwent MRI of the lumbar spine, dated 11/21/2013, showing 1-2 mm posterior disc bulge at L5-S1 level without evidence of canal stenosis or neural foraminal narrowing. There is no clear indication for a repeat MRI at this time. There was no worsening of subjective or objective complaints that would warrant such. The medical necessity was not established. Therefore, the request for MRI of the lumbar spine is not medically necessary.

**EMG/NCV BILATERAL LOWER EXTREMITIES: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines, (ODG), Low Back chapter, Nerve conduction studies (NCS).

**Decision rationale:** According to page 303 of CA MTUS ACOEM Low Back Chapter, the guidelines support the use of electromyography (EMG) to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three to four weeks. The Official Disability Guidelines state that the conduction studies are not recommended. There is minimal justification for performing nerve conduction studies when the patient is presumed to have symptoms on the basis of radiculopathy. In this case, patient complained of left-sided low back pain radiating to the left lower extremity. Patient denied weakness of both legs. Physical examination showed tenderness and restricted range of motion. Heel / toe ambulation was performed without difficulty. Straight leg raise was positive; however there was no indication of pain location. Sensation and motor strength were normal. Clinical manifestations are not consistent with a focal neurologic deficit that would warrant EMG. Of note, patient underwent MRI of the lumbar spine, dated 11/21/2013, showing no evidence of canal stenosis or neural foraminal narrowing. Regarding NCV, radiation of pain was only evident at the left lower

extremity. There was no subjective complaint or objective finding of the right lower extremity that would warrant an electrodiagnostic testing. Based on the aforementioned reasons, the request for EMG/nerve conduction velocity (NCV) study of bilateral lower extremities is not medically necessary.

**CYCLOBENZAPRINE 7.5MG #90: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants (for pain).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2, Cyclobenzaprine Page(s): 41-42.

**Decision rationale:** According to page 41-42 of the CA MTUS Chronic Pain Medical Treatment Guidelines, sedating muscle relaxants are recommended with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. In this case, patient has been prescribed Orphenadrine since July 2013. It is unclear why a different class of muscle relaxant in the form of Cyclobenzaprine should be added. Moreover, the most recent progress report cited absence of muscle spasm. Long-term use is likewise not recommended. Therefore, the request for Cyclobenzaprine 7.5mg #90 is not medically necessary.

**NAPROXEN 550MG #60: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2, NSAIDs Page(s): 46.

**Decision rationale:** As stated on page 46 of the California MTUS Chronic Pain Medical Treatment guidelines, NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain and that there is no evidence of long-term effectiveness for pain or function. In this case, patient has been on naproxen since July 2013. However, there was no documentation concerning pain relief and functional improvement derived from its use. Long-term use is likewise not recommended. Therefore, the request for Naproxen 550mg #60 is not medically necessary.

**OMEPRAZOLE 20MG #30: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms, and Cardiovascular Risk Page(s): 68.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2., NSAIDs, GI Symptoms, and Cardiovascular Risk Page(s): 68.

**Decision rationale:** As stated on page 68 of CA MTUS Chronic Pain Medical Treatment Guidelines, clinicians should weigh the indications for NSAIDs against both GI and cardiovascular risk factors: age > 65 years, history of peptic ulcer, GI bleeding or perforation; concurrent use of ASA, corticosteroids, or anticoagulant; or on high-dose/multiple NSAIDs.

Patients with intermediate risk factors should be prescribed proton pump inhibitors (PPI). In this case, there was no subjective report that patient was experiencing heartburn, epigastric burning sensation or any other gastrointestinal symptoms that will corroborate the necessity of this medication. Furthermore, patient did not meet any of the aforementioned risk factors. The guideline criteria were not met. Therefore, the request for Omeprazole 20mg #30 is not medically necessary.

**PHYSICAL THERAPY 2X4:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 2009, Physical Medicine Page(s): 98-99.

**Decision rationale:** As stated on pages 98-99 of the California MTUS Chronic Pain Medical Treatment Guidelines, physical medicine is recommended and that given frequency should be tapered and transition into a self-directed home program. In this case, patient underwent six sessions of physical therapy. Additional therapy visits are being requested to improve ROM and strength. However, the patient's response to previous treatment was not discussed. There was no objective evidence of overall pain improvement and functional gains derived from the treatment. It is unclear why patient cannot transition into a self-directed home exercise program. The medical necessity was not established. The request likewise failed to specify body part to be treated. Therefore, the request for Physical Therapy 2x4 is not medically necessary.