

<b>Case Number:</b>	CM13-0064915		
<b>Date Assigned:</b>	01/03/2014	<b>Date of Injury:</b>	11/02/2002
<b>Decision Date:</b>	06/09/2014	<b>UR Denial Date:</b>	11/21/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/12/2013

### 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 Physical Medicine and Rehabilitation 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:

Treatment to date has included acupuncture, use of H-wave unit, back support, and medications such as Cyclobenzaprine, Voltaren XR, and topical medications. Medical records from 2013 were reviewed showing that the patient complained of severe pain at the neck and left shoulder aggravated by reaching, lifting, pushing and pulling. Pain was associated with weakness, numbness and tingling of the left upper extremity with radiating pain to the left. Patient noted relief of pain with the use of medications. Pain resulted to difficulty sleeping. Physical examination showed muscle spasm with tenderness over the paracervical muscles and left trapezius. Range of motion of the cervical spine was limited to flexion and extension at 20 degrees. Range of motion of the left shoulder towards flexion and abduction was limited to 90 degrees. Reflexes and motor testing were normal. Sensation was diminished on the left hand.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**VOLTAREN XR 100MG, #60:** Upheld

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

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

**Decision rationale:** Page 46 of the California MTUS Chronic Pain Medical Treatment Guidelines state that non-steroidal anti-inflammatory drugs (NSAIDs) are effective, although they can cause gastrointestinal irritation or ulceration. There is no evidence of long-term effectiveness for pain or function. Therefore, they should be used only acutely. Voltaren XR is a brand name for Diclofenac. In this case, the patient has been using Voltaren XR since June 2013. However, medical records submitted and reviewed do not provide evidence of functional gains derived from its use. There is likewise no documentation regarding continued use despite the fact that it is only recommended for acute treatment. The guideline criteria have not been met. Therefore, the request for Voltaren XR 100 mg #60 is not medically necessary.

██████████ **ADJUSTABLE BED:** 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) REGARDING MATTRESS SELECTION.

**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, MATTRESS SELECTION.

**Decision rationale:** The CA MTUS does not specifically address this topic. Per the the Official Disability Guidelines (ODG), Low Back Section, there are no high quality studies to support purchase of any type of specialized mattress or bedding as a treatment for pain. Mattress selection is subjective and depends on personal preference. In this case, the rationale given for this request is to minimize further exacerbation to the spinal region and provide proper sleep. However, the clinical documentation submitted and reviewed fails to provide exceptional circumstances to support the purchase of a mattress. Furthermore, the guidelines do not recommend its purchase because there are no studies to support its treatment for pain. Therefore, the request for ██████████ adjustable bed is not medically necessary.

**ACUPUNCTURE 2 TIMES A WEEK FOR 8 WEEKS (16 VISITS):** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** As stated on pages 8-9 of CA MTUS Acupuncture Medical Treatment Guidelines, acupuncture may be used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation or to hasten functional recovery. It can be used to reduce pain and inflammation; and increase blood flow, and range of motion. The frequency and duration to produce functional improvement is 3 - 6 treatments, frequency of 1 - 3 times per week, and duration of 1 - 2 months. It may be extended if functional improvement is documented. In this case, the rationale given for this request is to reduce pain and decrease the need for oral medication. Medical records submitted and reviewed indicate that the patient underwent previous acupuncture sessions. However, the number of visits completed,

as well as functional gains derived from it were not documented. The guideline criteria for extending treatment with acupuncture have not been met. Therefore, the request for Acupuncture, 16 visits (2/wk for 8wks) is not medically necessary.

**FEXMID 7.5MG, #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxant Page(s): 63-64.

**Decision rationale:** Fexmid is a brand name of cyclobenzaprine, a skeletal muscle relaxant and a central nervous system depressant. According to CA MTUS Chronic Pain Medical Treatment Guidelines pages 63 to 64, non-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. However, in most LBP cases, they show no benefit beyond NSAIDs in pain and overall improvement. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. In this case, the patient has been taking Fexmid since June 2013. Although, physical examination revealed persistence of muscle spasm, long-term use is not recommended. Furthermore, there was no documented functional gains derived from its use. There is no discussion concerning the need for variance from the guidelines. Therefore, the request for Fexmid 7.5mg #60 is not medically necessary.

**FLURBIPROFEN/MENTHOL/CAMPHOR/CAPSAICIN TOPICAL COMPOUND CREAM:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

**Decision rationale:** As stated on pages 111-113 of the California MTUS Chronic Pain Medical Treatment Guidelines, topical analgesics are largely experimental in use with few randomized controlled trials to determine safety or efficacy. CA MTUS does not support flurbiprofen as an NSAID topical. Regarding the Capsaicin component, CA MTUS Chronic Pain Medical Treatment Guidelines on page 28 states that topical Capsaicin is only recommended as an option when there was failure to respond or intolerance to other treatments. In this case, patient has been using this topical medication since June 2013. There is no discussion of failure of oral medications. The requested compound topical is not recommended based on the guidelines stated above. There is no evidence concerning the need for variance from the guidelines. Therefore, the request for Flurbiprofen-menthol-camphor-capsaicin topical compound cream is not medically necessary.

**EMG/NCV UPPER EXTREMITIES:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints.

**Decision rationale:** The CA MTUS ACOEM guidelines state that electromyography (EMG) studies may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. Appropriate electrodiagnostic studies may help differentiate between carpal tunnel syndrome and other conditions, such as cervical radiculopathy. These include nerve conduction studies, or in more difficult cases, electromyography may be helpful. In this case, the rationale given for this request is to evaluate specific nerve entrapment, injury, disease, or muscle weakness. Patient has been complaining of chronic cervical pain radiating to the left upper extremity associated with weakness, numbness and tingling sensation corroborated by objective findings of diminished sensation at the left hand. The guideline criterion for presence of focal neurologic dysfunction has been met. Therefore, the request for EMG/NCV of upper extremities is medically necessary.

**URINE TOXICOLOGY TEST:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS.

**Decision rationale:** As stated on CA MTUS ACOEM Guidelines for the Chronic Use of Opioids, routine use of urine drug screening for patients on chronic opioids is recommended as there is evidence that it can identify aberrant opioid use. It is indicated for all patients on chronic opioid use for chronic pain. Screening is recommended randomly at least twice and up to 4 times a year. In this case, the rationale given for this request is because random drug screens are recommended. However, medical records submitted and reviewed do not provide evidence that patient has aberrant drug behavior. Moreover, the patient is not currently being prescribed with opioids that may necessitate the use of urine drug screen. There is likewise no citation regarding future plans to initiate opioid use. There is no discussion regarding the need for variance from the guidelines. Therefore, the request for urine toxicology test is not medically necessary.