

<b>Case Number:</b>	CM14-0104943		
<b>Date Assigned:</b>	08/06/2014	<b>Date of Injury:</b>	05/08/2014
<b>Decision Date:</b>	09/26/2014	<b>UR Denial Date:</b>	06/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/07/2014

### 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 Anesthesiology and Pain Medicine and is licensed to practice in Florida. 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 injured worker is a 41-year-old male who reported injuries due to cumulative/repetitive trauma on 05/08/2014. On 07/02/2014, his diagnoses included head pain, bilateral eye irritation/blurred vision, cervical spine musculoligamentous strain/sprain with radiculitis, cervical spine disc protrusion per MRI dated 06/09/2014, thoracic spine musculoligamentous strain/sprain, lumbar spine musculoligamentous strain/sprain with radiculitis, bilateral shoulder strain/sprain, right shoulder tendinitis, right shoulder impingement syndrome, bilateral elbow strain/sprain, bilateral elbow lateral medial epicondylitis, left elbow cubital tunnel syndrome per EMG/NCV, bilateral wrist sprain/strain, bilateral wrist chronic overuse syndrome, bilateral hand/wrist skin irritation, bilateral hip strain/sprain, bilateral knee strain/sprain, rule out bilateral knee internal derangement, bilateral foot plantar fasciitis, sleep disturbance secondary to pain, and situational depression. His complaints included headaches as well as pain in the neck/mid/upper back, lower back, bilateral shoulders/arms, bilateral elbow/forearm, bilateral hips/thighs, bilateral knees, bilateral ankles/feet, and bilateral wrists/hands. There was tenderness to palpation in the cervical, thoracic and lumbar spine, the bilateral shoulders and arms, bilateral elbows, forearms and wrists, the bilateral hands, hips, thighs, knees, ankles and feet. It was noted that he had completed 8 sessions of physical therapy out of scheduled 12 sessions. He stated that the physical therapy helped him reduce his pain and tenderness. An MRI of the cervical spine dated 06/09/2014 revealed posterior disc herniation with no significant stenosis of the spinal canal or neural foramen C3 through C7. There was no rationale included in this worker's chart. A request for authorization dated 05/21/2014 was included

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cyclobenzaprine 7.5mg #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-64.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines muscle relaxants Page(s): 63-66.

**Decision rationale:** The request for cyclobenzaprine 7.5 mg #60 is non-certified. The California MTUS Guidelines recommend that muscle relaxants be used with caution as a second line option for short-term treatment of acute exacerbations in patients with chronic low back pain. In most low back pain cases, they show no benefit beyond NSAIDs. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. Limited, mixed evidence does not allow for a recommendation of chronic use. Cyclobenzaprine is a skeletal muscle relaxant and a central nervous system depressant. It is not recommended for use longer than 2 to 3 weeks. The submitted documentation reveals that this worker has been using cyclobenzaprine since 05/28/2014, which exceeds the 2 to 3 weeks recommended in the guidelines. Additionally, this worker has a diagnosis of depression. A central nervous system depressant should be used with caution in depressed patients. Additionally, there was no frequency of administration included in the request. Therefore, this request for cyclobenzaprine 7.5 mg #60 is non-certified.

**TGHOT 180 Grams and Fluriflex 180 Grams: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 211.

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

**Decision rationale:** The request for TGHOT 180 grams and Fluriflex 180 grams is non-certified. The California MTUS Guidelines refer to topical analgesics as largely experimental with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Many agents are compounded for pain control. There is little to no research to support the use of many of these agents. The ingredients in TGHOT are tramadol 8%, gabapentin 10%, menthol 2%, camphor 2% and capsaicin 0.05%. Capsaicin is generally available as a 0.025% formulation. There have been no studies of a 0.05% formulation of capsaicin and there is no current indication that this increase over a 0.025% formulation would provide any further efficacy. Gabapentin is not recommended. There is no peer-reviewed literature to support use. The ingredients in Fluriflex are flurbiprofen 10% and cyclobenzaprine 10%. There is no evidence for use of any muscle relaxant as a topical product. Additionally, the body part or parts to which these creams were supposed to have been applied was not included in the request. Furthermore, there was no

frequency of application included in the request. Therefore, the request for TGHOT 180 grams and Fluriflex 180 grams is non-certified.

**Lumbosacral Brace:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308.

**Decision rationale:** The request for lumbosacral brace is non-certified. The California MTUS/ACOEM Guidelines do not recommend lumbar supports for acute lumbar spine disorders. Lumbar support is not recommended for the treatment of low back disorders. Lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. Additionally, the request did not specify whether the requested lumbosacral brace was custom made or prefabricated nor the size of the brace. Additionally, it did not specify frequency of use. Therefore, this request for lumbosacral brace is non-certified.

**Interferential Unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-120.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-119.

**Decision rationale:** The request for interferential unit is non-certified. The California MTUS Guidelines do not recommend interferential current stimulation as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and postoperative knee pain. Although it has been proposed for treatment in general for soft tissue injury or for enhancing wound or fracture healing, there was insufficient literature to support interferential current stimulation for treatment of these conditions. There are no standardized protocols for the use of interferential therapy; the therapy may vary according to the frequency of stimulation, the pulse duration, treatment time, and electrode-placement technique. Additionally, the body part or parts for which this interferential unit was to have been applied was not specified nor were there any parameters for frequency of stimulation, pulse duration, treatment time or electrode placement. Therefore, this request for interferential unit is non-certified.

**Hot & Cold Unit:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment section for low back and neck under the heading of cold packs.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Thermotherapy and Cold packs.

**Decision rationale:** The request for hot and cold unit is non-certified. The Official Disability Guidelines note that thermal therapy is understudy. For several physical therapy interventions and indications including thermotherapy using heat, there was a lack of evidence regarding efficacy. Cold packs are recommended. Additionally, the body part or parts to which this unit was to have been applied were not specified. Furthermore, there was no frequency of application included in the request. Therefore, this request for hot and cold unit is non-certified.

**EMG Bilateral Upper Extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck, Electromyography (EMG) and nerve conduction studies.;American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Electromyography (EMG).

**Decision rationale:** The request for EMG bilateral upper extremities is non-certified. The California MTUS/ACOEM Guidelines recommend the importance of determining whether or not there is cervical nerve root compromise. The Official Disability Guidelines recommend needle, not surface electromyography. A positive diagnosis of radiculopathy requires the identification of neurogenic abnormalities in 2 or more muscles that share the same nerve root innervation but differ in their peripheral nerve supply. Additionally, the injured worker's diagnoses revealed that he had bilateral elbow lateral and medial epicondylitis and left cubital tunnel syndrome that was confirmed by EMG. There was no rationale or justification for a repeat EMG. Furthermore, his cervical MRI showed no radiculopathy. Therefore, this request for EMG bilateral upper extremities is non-certified.

**NCV Bilateral Upper Extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck, Electromyography (EMG) and nerve conduction studies.

**Decision rationale:** The request for NCV bilateral upper extremities is non-certified. The California MTUS/ACOEM Guidelines stress the importance of determining whether or not there is cervical nerve root compromise. The Official Disability Guidelines do not recommend nerve root conduction studies to demonstrate radiculopathy, if radiculopathy has already been clearly identified by EMG and obvious clinical signs. This worker's diagnoses included bilateral elbow lateral/medial epicondylitis per NCV. There was no rationale or justification for a repeat study. Additionally, the cervical MRI showed that there was no radiculitis. Therefore, this request for NCV of bilateral upper extremities is non-certified.

**MRI of Cervical Spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179.

**Decision rationale:** The request for MRI of the cervical spine is non-certified. The California ACOEM Guidelines recommend that relying solely imaging studies to evaluate the source of cervical pain and related symptoms carries a significant risk of diagnostic confusion, including false positive test results, such as identifying a finding that was present before symptoms began and therefore had no temporal association with the symptoms. False positive results have been found and up to 50% of those over the age of 40. This worker had an MRI of the cervical spine on 06/09/2014. There was no rationale or justification for repeat MRI. Therefore, this request for MRI of cervical spine is non-certified.

**Consultation Ophthalmologist:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Ch.7 pg. 127.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 77-89.

**Decision rationale:** The request for consultation ophthalmologist is non-certified. The California ACOEM Guidelines recommend that under the optimal system, a clinician acts as the primary case manager. The clinician provides appropriate medical evaluation and treatment and adheres to a conservative, evidence based treatment approach that limits excessive physical medicine usage and referral. The clinician should judiciously select and refer to specialists who will support functional recovery as well as provide expert medical recommendations. Although this worker does have a diagnosis of bilateral eye irritation/blurred vision, there was no documented evidence of previously failed trials of conservative treatment including eye drops and/or ointments to treat this condition. Additionally, there was no documentation of whether or not this worker wore glasses and whether or not he had had a recent exam by an optometrist. The clinical information submitted failed to meet the evidence-based guidelines for referral. Therefore, this request for consultation ophthalmologist is non-certified.

**Physical Performance, Functional Capacity Evaluation: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Ch.7 pg. 138.

**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, Flexibility and Forearm, Wrist, & Hand, Computerized muscle testing.

**Decision rationale:** The request for physical performance, Functional Capacity Evaluation is non-certified. The Official Disability Guidelines do not recommend computerized muscle testing as a primary criteria and state that muscle testing should be a part of a routine musculoskeletal evaluation. The relation between lumbar range of motion measures and functional ability is weak or non-existent. The guidelines further state that an inclinometer is the preferred device for obtaining acute, reproducible measurements in a simple, practical and inexpensive way. The guidelines do not recommend computerized measures of lumbar spine and range of motion which can easily be done with inclinometers, and where the resultant range of motion is unclear. Additionally, the body part or parts that were to have been evaluated were not specified. Therefore, this request for physical performance, Functional Capacity Evaluation is non-certified.

**Physical Therapy Evaluation and Treatment 2 times a week for 6 weeks for cervical, thoracic and lumbar spine, bilateral shoulders, bilateral elbows/forearms, bilateral wrists/hands, bilateral knees, bilateral feet: Upheld**

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

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

**Decision rationale:** The request for physical therapy evaluation and treatment 2 times a week for 6 weeks for cervical, thoracic and lumbar spine, bilateral shoulders, bilateral elbows/forearms, bilateral wrists/hands, bilateral knees, bilateral feet is non-certified. The California MTUS Guidelines recommend active therapy as indicated for restoring flexibility, strength, endurance, function, range of motion, and to alleviate discomfort. Patients are expected to continue active therapies at home. The physical medicine guidelines allow for fading of treatment frequency from up to 3 visits per week to 1 or less, plus active self-directed home physical medicine. The recommended schedule for myalgia and myositis is 9 to 10 visits over 8 week weeks. It was noted in this worker's documentation that he had already completed 8 sessions of physical therapy and was scheduled for 4 more sessions which exceeds the recommendations in the guidelines. Therefore, this request for physical therapy evaluation and treatment 2 times a week for 6 weeks for cervical, thoracic and lumbar spine, bilateral shoulders, bilateral elbows/forearms, bilateral wrists/hands, bilateral knees, bilateral feet is non-certified.