

<b>Case Number:</b>	CM14-0016313		
<b>Date Assigned:</b>	04/11/2014	<b>Date of Injury:</b>	01/12/2013
<b>Decision Date:</b>	05/29/2014	<b>UR Denial Date:</b>	01/15/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/10/2014

### 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 Pain Medicine 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:

This is a 42-year-old female who sustained injury on 01/12/2013 while she was rear-ended by another vehicle. She reported injury to her neck, back, head, knees, and hands. The treatment history includes physical therapy, acupuncture, and medications. A progress report dated 01/08/2014 indicates the patient complained of pain in cervical spine, thoracic spine, lumbar spine, bilateral knees, head, bilateral wrists/hands, and bilateral hips. On exam, Cervical: there was +3 spasm and tenderness to the bilateral paraspinal muscles from C2 to C7, bilateral suboccipital muscles and bilateral upper shoulder muscles. Axial compression test was positive bilaterally for neurological compromise. Distraction test was positive bilaterally. Shoulder depression test was positive bilaterally. The right biceps and brachioradialis reflexes were decreased. Thoracic: There was +3 spasm and tenderness to the bilateral thoracic paraspinal muscles from T4 to T9. Lumbar: There was +3 spasm and tenderness to the bilateral lumbar paraspinal muscles from L1 to S1 and multifidus. Kemp/Yeoman tests were positive bilaterally. Right Achilles reflex was decreased. Wrists and Hands: There was +3 spasm and tenderness to the bilateral anterior wrists. Tinel (carpal) test was positive bilaterally. Bracelet test was positive bilaterally. Hips: There was +3 spasm and tenderness to the bilateral gluteus medius muscles, tensor fasciae latae muscles and acetabular joints. Fabere test was positive bilaterally. Anvil test was positive bilaterally. Knees: There was +3 spasm and tenderness to the bilateral anterior joint lines and vastus medialis muscles. Varus and McMurray tests were positive bilaterally. Diagnoses were cervical disc herniation without myelopathy, thoracic disc displacement without myelopathy, lumbar disc displacement without myelopathy, carpal sprain/strain of bilateral wrists, tear of medial meniscus of bilateral knees, bursitis of the bilateral knees, and tendinitis/bursitis of the bilateral hips.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**COMPOUND TOPICAL FLURBIPROFEN 15%/CLYCLOBENZAPRINE 10%:** 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): 11-113.

**Decision rationale:** According to the California MTUS guidelines, muscle relaxants, such as Cyclobenzaprine, are not recommended for topical formulation. As per the guidelines, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Consequently, this topical compound is not recommended under the guidelines, and therefore, the medical necessity of this topical compound is not established.

**COMPOUND TOPICAL TRAMADOL 8%, GABAPENTIN 10%, MENTHOL 2%, CAMPHOR 2%, CAPSAICIN .05%:** 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:** According to the California MTUS guidelines, topical analgesics are considered to be largely experimental in use with few randomized controlled trials to determine efficacy or safety. According to the guidelines, Gabapentin is not recommended for topical formulations. The guidelines state that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Furthermore, the medical records do not establish this patient has failed standard conservative measures. Consequently this compounded product is not supported by the evidence based guidelines. The medical necessity is not established.

**12 PHYSICAL THERAPY/CHIROPRACTIC VISITS FOR CERVICAL AND LUMBAR SPINE:** 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 Physical Medicine Page(s): 98-99.

**Decision rationale:** The California MTUS guidelines state "manual therapy/manipulation is recommended for chronic pain if caused by musculoskeletal conditions. 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. Elective/maintenance care - Not medically necessary. Recurrences/flare-ups - Need to reevaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months." According to the CA MTUS, physical medicine is recommended as indicated, "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. Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks, Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2), 8-10 visits over 4 weeks." The most recent progress report is more than three months old, and as such, does not reflect the patient's current findings. The patient is more than one year post date of injury. According to the submitted progress reports, the patient's treatment history has included numerous PT and chiropractic visits as well as acupuncture sessions. However, the medical records do not include any details regarding the patient's treatment history. The medical records do not establish this patient presents with a clear recent flare-up or exacerbation that is likely to benefit from a return to chiropractic care or physical therapy. At this juncture, the patient should be versed in an independent therapeutic program. The medical records do not establish the requested PT/chiropractic is medical necessary.

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

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 182,303.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 178, 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck Electromyography, (EMG) Nerve conduction studies (NCS); Low Back, Electrodiagnostic studies (EDS).

**Decision rationale:** The California MTUS/ACOEM states when the neurologic examination is less clear, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. Electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. According to the ODG, electrodiagnostic studies may be recommended as an option in selected cases. The NCV is not generally recommended to demonstrate radiculopathy. The PR-2 reports document examination findings of positive subjectively driven orthopedic maneuvers and neurologic tests, pain with motion and spasms. It is stated in the medical records that the patient has undergone MRI studies of the cervical and lumbar spines. However the studies were not included in the medical records. The results of these imaging studies should be evaluated. The medical records do not establish the necessity for bilateral upper and lower extremity electrodiagnostic studies. The medical necessity for EMG/NCV of the bilateral upper and lower extremities is not established.

**INITIAL PAIN MANAGEMENT EVALUATION:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-TWC Pain Procedure Summary.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 92.

**Decision rationale:** According to the guidelines, a specialty referral may be indicated if the practitioner is uncomfortable with the line of inquiry outlined above, with treating a particular cause of delayed recovery (such as substance abuse), or has difficulty obtaining information or agreement to a treatment plan. The medical records do not establish such is the case of this patient. The 1/8/2014 progress report states the patient is pending a pain management consultation for her cervical and lumbar spine based on the positive MRI findings. However, the medical records do not include the official results of the study findings. The medical records do not include current examination findings. The medical records do not establish this patient is a candidate for any invasive pain management procedures. Medication management can be properly executed by her primary care provider. The medical necessity for an initial pain management evaluation is not established.

**ORTHOPEDIC SURGICAL CONSULT FOR THE LEFT KNEE: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-TWC Pain Procedure Summary.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 343-344.

**Decision rationale:** The California MTUS/ACOEM states referral for surgical consultation may be indicated for patients who have activity limitation for more than one month and failure of exercise programs to increase range of motion and strength of the musculature around the knee. Referral for early repair of ligament or meniscus tears is still a matter for study because many patients can have satisfactory results with physical rehabilitation and avoid surgical risk. According to the medical records, the patient had undergone an MRI of the left knee. The medical records do not include the results of the test. The medical records do not document current objective examination findings. There is insufficient current documentation to establish this patient is surgical candidate. Consequently, the medical necessity for an orthopedic surgical consult for the left knee is not established.

**FUNCTIONAL CAPACITY EVALUATION: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 81. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Fitness for Duty, Functional capacity evaluation (FCE).

**Decision rationale:** The California MTUS/ACOEM states, "Consider using a functional capacity evaluation when necessary to translate medical impairment into functional limitations and determine work capability." ODG states "Functional Capacity Evaluation - Not recommend routine use as part of occupational rehab or screening, or generic assessments in which the question is whether someone can do any type of job generally." The medical records do not establish that a functional capacity evaluation is medically indicated for the management of this patient. There is no documented failed return to work attempts, conflicting medical reporting on precautions or fitness to perform modified job duties, or that she has injuries that require detailed exploration of her abilities. In addition, the physician's reports state the patient is not permanent and stationary. The patient is not considered at or close to MMI. Consequently, the medical necessity of a functional capacity evaluation has not been established. The request is not supported by the evidence-based guidelines.