

<b>Case Number:</b>	CM14-0122143		
<b>Date Assigned:</b>	08/06/2014	<b>Date of Injury:</b>	03/09/2011
<b>Decision Date:</b>	09/23/2014	<b>UR Denial Date:</b>	06/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/01/2014

### 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 Orthopedic Surgery 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 42-year-old female management analyst sustained an industrial injury on 3/9/11 relative to repetitive work activities. The 5/6/11 bilateral upper extremity EMG/NCV impression documented a normal study with no evidence of carpal tunnel syndrome, ulnar or radial neuropathy, or cervical radiculopathy. She underwent left shoulder arthroscopic surgery on 7/12/12. Records indicated that a cervical MRI was performed in March 2013. The treating physician progress report relative to exam date 6/16/14 cited persistent grade 9/10 neck, bilateral shoulder, and right wrist and hand pain. Pain reduced from 9/10 to 5/10 with rest and medications. Pain was worse with sitting, driving, and any activity requiring cervical rotation. She had completed 1 of 8 physical therapy sessions for the left shoulder. Cervical exam documented decreased range of motion, upper extremity tenderness and hypertonicity, positive shoulder depression test, and positive Spurling's on the left. Muscle strength was decreased to 4/5 bilaterally at C5, C6, C7, and C8. Sensation was decreased over the C7 and C8 dermatomes on the left. Deep tendon reflexes were +2 and symmetrical. Bilateral shoulder exam documented significantly decreased range of motion, acromioclavicular joint tenderness, and 4/5 flexion and abduction strength on the left. Bilateral hand exam documented decreased range of motion, positive Phalen's and Tinel's on the right, decreased median nerve sensation on the right, and decreased left grip strength. Authorization was pending chiropractic treatment, cervical MRI, bilateral upper extremity EMG/NCV, ergonomic workstation, and Flurbiprofen/Cyclobenzaprine gel. The patient was reported at modified work. The 6/24/14 utilization review modified the request for 12 chiropractic visits to 8 visits consistent with guidelines. The requests for cervical MRI, upper extremity EMG/NCV and topical Flurbiprofen/Cyclobenzaprine/Menthol Cream were denied based on lack of guidelines support. The request for ergonomic workstation was

conditionally non-certified based on lack of sufficient information to make a decision of medical necessity.

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

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

### **12 Chiropractic Therapy Visits for the cervical spine: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation. Decision based on Non-MTUS Citation Official Disability Guidelines-Regional Neck Pain.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MANUAL THERAPY AND MANIPULATION Page(s): 58.

**Decision rationale:** The California MTUS guidelines support chiropractic manipulation for chronic pain if caused by musculoskeletal conditions. The intended goal of manual medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Guidelines state that 4 to 6 treatments allow time to produce an effect. If there is evidence of objective functional improvement with initial care and documentation of residual functional deficits, additional chiropractic treatment may be supported. The 6/24/14 utilization review modified the request for 12 chiropractic sessions to 8 sessions. Records indicate the patient is also attending physical therapy. There is no compelling reason to support the medical necessity of additional chiropractic treatment without evidence of objective measurable functional improvement with the initial 8 visits. Therefore, this request is not medically necessary.

### **MRI of the cervical spine: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck & Upper Back (Acute & Chronic).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178, 182. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back, Magnetic resonance imaging (MRI).

**Decision rationale:** The California MTUS guidelines provide criteria for ordering cervical spine MRIs that includes emergence of a red flag, physiologic evidence of tissue insult or neurologic dysfunction, failure in a strengthening program intended to avoid surgery, or clarification of anatomy prior to an invasive procedure. The Official Disability Guidelines state that repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (e.g., tumor, infection, fracture, neurocompression, recurrent disc herniation). Guideline criteria have not been met. This patient is currently attending a physical therapy program and has been certified for chiropractic

treatment. There is no indication of a significant change in symptoms and/or findings to support the medical necessity of repeat MRI at this time. Therefore, this request is not medically necessary

**EMG of bilateral upper extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 261. Decision based on Non-MTUS Citation Official Disability Guidelines, Carpal Tunnel Syndrome (Acute & Chronic).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 8 Neck and Upper Back Complaints Page(s): 182; 269.

**Decision rationale:** The California MTUS guidelines support EMG in upper extremity complaints if cervical radiculopathy is suspected as a cause of lateral arm pain and that condition has been present for at least 6 weeks. EMG is recommended if carpal tunnel syndrome is suspected. Guideline criteria have not been met. Prior electrodiagnostic testing was performed on 5/6/11 and was negative for cervical radiculopathy and carpal tunnel syndrome. The current right upper extremity exam is suggestive of carpal tunnel syndrome. However, the medical necessity of bilateral upper extremity EMG is not documented. Current conservative treatment is in process. Therefore, this request is not medically necessary.

**NCV of bilateral upper extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 261. Decision based on Non-MTUS Citation Official Disability Guidelines, Carpal Tunnel Syndrome (Acute & Chronic).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 182; 269.

**Decision rationale:** The California MTUS guidelines indicate that NCV testing is supported to diagnose carpal tunnel syndrome. Guideline criteria have not been met. .Prior electrodiagnostic testing was performed on 5/6/11 and was negative for cervical radiculopathy and carpal tunnel syndrome. The current right upper extremity exam is suggestive of carpal tunnel syndrome. However, the medical necessity of bilateral upper extremity NCV is not documented. Current conservative treatment is in process. Therefore, this request is not medically necessary.

**Flurbiprofen/Cyclobenzaprine/Menthol Cream (20%/10%/4%), 180gm:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics/NSAID's.

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

**Decision rationale:** The California MTUS guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Topical agents are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many of these agents. Guidelines state that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Guidelines state there is no evidence for use of a muscle relaxant, such as cyclobenzaprine, as a topical product. Guidelines do not recommend topical non-steroid anti-inflammatory drugs (NSAIDs), like Flurbiprofen, for neuropathic pain and state there is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine or shoulder. Given the absence of guideline support for all components of this product, this product is not recommended by guidelines. Therefore, this request is not medically necessary.