

Case Number:	CM14-0179663		
Date Assigned:	11/04/2014	Date of Injury:	02/20/2014
Decision Date:	12/09/2014	UR Denial Date:	10/08/2014
Priority:	Standard	Application Received:	10/29/2014

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 & 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:

The injured worker is a 57-year-old female who reported an injury on 02/20/2014 while doing her job duties as a laundry person that included pushing and pulling large containers of soiled linens, sorting linens, putting linens to wash, dry, folding and stacking them for use for the housekeepers. The injured worker developed pain in the neck, right shoulder, arm, hand and low back secondary to repetitive use of upper extremities. Diagnoses were: shoulder arthritis, degenerative; shoulder acromioclavicular joint arthritis; shoulder arthralgia and wrist arthralgia; cervical degenerative disc disease; cervicalgia; other tenosynovitis, hand/wrist; sprain shoulder/arm; and cervical myofascial sprain/strain. Past treatments were medications, massage therapy, and physical therapy. The injured worker had an electromyography (EMG)/nerve conduction velocity (NCV) study that revealed right carpal tunnel syndrome and bilateral elbow tendinitis. The injured worker had an MRI of the right shoulder that revealed tendinitis and bursitis. The injured worker also had an MRI of the neck. These studies were not available. The injured worker attended physical therapy but after the first session she developed increased swelling on the right side of her neck, face and right shoulder. The therapy was stopped. The injured worker was referred for acupuncture therapy where she received 1 visit and developed swelling in her right shoulder, right side of neck and face. Physical examination on 09/22/2014 revealed that the injured worker noted slight improvement in her condition since the last visit. Pain was now less frequent and less severe. Current medications were Flexeril, Mobic 15 mg, and Voltaren 1% gel. Examination of the cervical spine revealed tenderness and stiff range of motion. Examination of the right shoulder revealed right trapezius tenderness, abduction at 175 degrees, negative drop test, and negative impingement. Examination of the right wrist revealed normal range of motion, negative Phalen's sign, and negative Tinel's sign. Treatment plan was for application of heat/ice as needed, topical analgesic ointment application, stretch and strength

home exercise program, and over the counter analgesics/anti-inflammatory medications as needed. The rationale and Request for Authorization were not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pain management consultation for the consideration of a cervical epidural injection:

Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 175. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Management Referral, CMTUS Introduction Page(s): 1.

Decision rationale: The decision for pain management consultation for the consideration of a cervical epidural injection is not medically necessary. The request for referral to pain management specialist for evaluation and treatment is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines state that if the complaint persists, the physician needs to reconsider the diagnosis and decide whether a specialist evaluation is necessary. The clinical documentation provides no evidence that the current treatment requested has failed to result in improvement in the injured worker's pain complaints or that she requires complex pain management for control of her shoulder complaints. The injured worker stated in physical examination 09/22/2014 that her pain has improved. Based on the submitted documentation reviewed and the medical guidelines, a pain management consultation would not be indicated. Therefore, the request is not medically necessary.

Home transcutaneous electrical nerve stimulation (TENS) unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS; NMES; Interferential Current Stimulation Page(s): 114-116; 121; 118.

Decision rationale: The decision for home TENS unit is not medically necessary. The California Medical Treatment Utilization Schedule recommends a 1 month trial of a TENS unit as an adjunct to a program of evidence based functional restoration for chronic neuropathic pain. Prior to the trial there must be documentation of at least 3 months pain, and evidence that other appropriate pain modalities have been tried (including medication) and have failed. They do not recommend neuromuscular electrical stimulation (NMES devices) as there is no evidence to support its use in chronic pain. They do not recommend interferential current stimulation (ICS) as an isolated intervention. The clinical documentation submitted reported that the injured worker had 1 session of physical therapy. The medical guidelines state that there should be 3 months of pain and evidence that other appropriate pain modalities have been tried and have

failed. The clinical information submitted does not meet the medical guidelines recommendation. Also the guidelines recommend that a TENS unit should be used in adjunct with a program of evidence based functional restoration. Therefore, the request is not medically necessary.

MRI of the cervical spine: 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), Neck and Upper Back Chapter

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-179, 182.

Decision rationale: The decision for MRI of the cervical spine is not medically necessary. The California ACOEM states unequivocal objective findings that identify specific nerve compromise on the neurological examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery as an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminate imaging will result in false positive finding, such as disc bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause: magnetic resonance imaging (MRI) for neural or other soft tissue; computer tomography (CT) for bony structures. MRIs are recommended for acute neck and upper back conditions when red flags for fracture, or neurologic deficit associated with acute trauma, tumor, or infection are present. The physical examination on 09/22/2014 did not report any red flags on the physical examination. There were no neurological deficits reported. The injured worker reported that her symptoms were improving. Therefore, the request is not medically necessary.

Neurology consultation for an electromyography (EMG)/nerve conduction velocity (NCV): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): table 11-7. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 6, page 163

Decision rationale: The American College of Occupational and Environmental Medicine Guidelines state that a consultation is intended to aid in assessing the diagnosis, prognosis, therapeutic management, determination of medical stability and permanent residual loss and/or the examinee's fitness for return to work. There was no clear rationale to support the consultation. The injured worker reported that her pain was improving on physical examination

dated 09/22/2014. There were no significant functional deficits reported on the examination. There was no rationale provided detailing a clear indication for why the injured worker needed a neurology consultation. Therefore, this request is not medically necessary.

Voltaren Gel 1%: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics; Diclofenac Page(s): 111; 71.

Decision rationale: The decision for Voltaren gel 1% is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines indicate that topical analgesics are largely experimental in use 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. Any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. Voltaren 1% gel is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment. The injured worker was not diagnosed with osteoarthritis; also, the request does not indicate the frequency for the medication. The efficacy of this medication was not provided. Also there was no quantity for the medication reported. Therefore, this request is not medically necessary.

Flexeril 10 mg, sixty count: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 41,64.

Decision rationale: The decision for Flexeril 10 mg, sixty count is not medically necessary. The California Medical Treatment Utilization Schedule states that cyclobenzaprine (Flexeril) is recommended for a short course of therapy. Flexeril is more effective than placebo in the management of back pain; however, the effect is modest and comes at the price of greater adverse effects. The effect is greatest in the first four days of treatment, suggesting that shorter courses may be better. This medication is not recommended to be used for longer than 2 to 3 weeks. The efficacy of this medication was not reported. There is a lack of documentation of objective functional improvement. Also, the request does not indicate a frequency for the medication. Therefore, the request is not medically necessary.