

<b>Case Number:</b>	CM14-0039465		
<b>Date Assigned:</b>	07/30/2014	<b>Date of Injury:</b>	11/29/2010
<b>Decision Date:</b>	09/11/2014	<b>UR Denial Date:</b>	03/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/03/2014

### 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 Illinois. 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 34-year-old female who reported an injury on 11/29/2010. The mechanism of injury was not stated. Current diagnoses include cervical spine sprain, thoracic spine sprain, lumbar spine sprain with disc protrusion, bilateral shoulder tendonitis, bilateral wrist cyst with avascular necrosis, and bilateral ankle and foot pain. The injured worker was evaluated on 01/15/2014 with complaints of constant pain over multiple areas of the body. Physical examination only revealed positive paraspinal tenderness with positive impingement sign. Treatment recommendations included a pain management referral, an MRI, an internal medicine consultation, acupuncture therapy, and a Functional Capacity Evaluation. A Request for Authorization was also submitted on 01/15/2014 for extracorporeal shockwave therapy, acupuncture, pain management, cyclobenzaprine 7.5 mg, naproxen 550 mg, omeprazole 20 mg, and 4 compounded creams.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Pain Management:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 7: Independent Medical Examinations and Consultations, page 127.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92.

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state a referral may be appropriate if the practitioner is uncomfortable with the line of inquiry, with treating a particular cause of delayed recovery, or has difficulty obtaining information or an agreement to a treatment plan. As per the documentation submitted, the injured worker is pending authorization for several physical modalities and imaging studies. There is no documentation of an exhaustion of conservative treatment prior to the request for a specialty referral. As the medical necessity has not been established, the request is not medically necessary and appropriate.

**Acupuncture 2 times per week for 4 weeks:** Upheld

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

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

**Decision rationale:** California MTUS Guidelines state acupuncture is used as an option when pain medication is reduced or not tolerated and may be used as an adjunct to physical rehabilitation and/or surgical intervention. The time to produce functional improvement includes 3 to 6 treatments. Therefore, the current request for 8 sessions of acupuncture exceeds guideline recommendations. There is also no specific body part listed in the current request. As such, the request is not medically necessary.

**Cyclobenzaprine 7.5mg, #90:** Upheld

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

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

**Decision rationale:** California MTUS Guidelines state muscle relaxants are recommended as nonsedating second line options for short term treatment of acute exacerbations. Cyclobenzaprine should not be used for longer than 2 to 3 weeks. There was no frequency listed in the current request. There was also no documentation of palpable muscle spasm or spasticity upon physical examination. As such, the request is not medically necessary.

**Ortho consultation:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 7: Independent Medical Examinations and Consultations, page 127.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92.

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state a referral may be appropriate if the practitioner is uncomfortable with the line of inquiry, with treating a particular cause of delayed recovery, or has difficulty obtaining information or an agreement to a treatment plan. As per the documentation submitted, the injured worker is pending authorization for several physical modalities and imaging studies. There is no documentation of an exhaustion of conservative treatment prior to the request for a specialty referral. As the medical necessity has not been established, the request is not medically necessary and appropriate.

**FlurLido-A 240gm:** Upheld

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

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

**Decision rationale:** California MTUS Guidelines state 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. There is no documentation of a failure to respond to first line oral medication prior to the initiation of a topical analgesic. There was also no strength or frequency listed in the current request. As such, the request is not medically necessary.

**FlurLido-A 30gm:** Upheld

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

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

**Decision rationale:** California MTUS Guidelines state 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. There is no documentation of a failure to respond to first line oral medication prior to the initiation of a topical analgesic. There was also no strength or frequency listed in the current request. As such, the request is not medically necessary.

**Ultraflex-G 240gm:** Upheld

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

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

**Decision rationale:** California MTUS Guidelines state 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. There is no documentation of a failure to respond to first line oral medication prior to the initiation of a topical analgesic. There was also no strength or frequency listed in the current request. As such, the request is not medically necessary.

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**Extracorporeal Shockwave Therapy (ESWT) once (1) per week for 4-6 weeks:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-300.

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state physical modalities have no proven efficacy in treating acute low back symptoms. There was no specific body part listed in the current request. Therefore, the request is not medically necessary and appropriate.