

<b>Case Number:</b>	CM14-0044855		
<b>Date Assigned:</b>	08/06/2014	<b>Date of Injury:</b>	03/08/2000
<b>Decision Date:</b>	09/24/2014	<b>UR Denial Date:</b>	03/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/11/2014

### 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 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 patient is a 56-year-old-male who suffered an industrial injury on 03/08/2000. The patient sustained injury while working as a fisheries habitat assistant technician for the [REDACTED]. He has neck pain radiating down both arms, upper back and bilateral shoulder pain. His neck and upper back pain is described as sharp, dull, aching, and shooting. He has cramping pressure and burning in his abdomen. His neck has 95% of pain and his arms has 5% of pain. He functionally needs some assistance with ADLs and uses a cane for ambulation. On cervical spine exam, no cervical lordosis, asymmetry or abnormal curvature noted. ROM is restricted with flexion limited to 40 degrees, extension limited to 25 degrees, right/left lateral bending limited to 15 degrees, and lateral rotation to the left/right limited to 35 degrees. On thoracic spine exam, no scoliosis, asymmetry or abnormal curvature noted. Exam of paravertebral muscles shows hypertonicity, spasm, tenderness, tight muscle band and trigger point (a twitch response was obtained along with radiating pain on palpation) is noted on both sides. Spinous process tenderness is noted on T1. Trigger point with radiating pain and twitch response on palpation at cervical paraspinal muscles on right and left trapezius muscle right and left supraspinatus muscle on right and left T2-T7. Requested treatment: H-wave to address pain complaints and avoid escalation of medication. Labs & Diagnostics: MRI of MRI/MRA to bilateral brachial plexus to evaluate for thoracic outlet syndrome. Referral to Functional Restoration for multi-disciplinary evaluation. He currently takes Ibuprofen, Lidocaine Ointment, Neurontin, Kadian ER, Morphine, Skelaxin, Amrix ER. Failed Meds are: Darvocet-high feeling, dizzy, diaphoresis; duragesic patch-allergy to adhesives; tylenol #3; oxycontin-high, vicodin-high, flexeril-high feeling, dizzy, diaphoresis; lidoderm-allergy to adhesives; naproxyn-liver and GI issues; ambien-sluggish, foggy; remeron-rapid weight gain, caused NASH; trazodone-high feeling, dizzy, diaphoresis, sluggish, foggy; sonata-sluggish, foggy; klonopin-sluggish, foogy;

xanax-sluggish, foggy; prozac-high feeling, dizzy, diaphoresis; sizone-high feeling, dizzy, diaphoresis; wellbutrin-anxious figety; zoloft-high feeling, dizzy, diaphoresis, lyrica-high feeling, dizzy, diaphoresis. Patient is allergic to cats. Diagnosis are spasm of muscle, cervical pain, extremity pain, shoulder pain, and thoracic outlet syndrome. UR request determination for items non-certified are: DME purchase H-wave unit; and multidisciplinary evaluation for functional restoration program; request of Amrix ER 15mg qty 60; for Ibuprofen 400mg, qty 60; Lidocaine 5% Ointment qty 1; MRI Thoracic Spine w/wo contrast; DME Thoracic outlet figure 8 brace; MRI/MRA bilateral Brachial Plexus; Retrospective request for Urine Drug Screen, dos 03/06/14. Items partially certified are: Neurontin 300mg, qty180, modified to Neurontin 300mg qty 90.

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

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

#### **DME Purchase of H-wave Unit: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines H-wave stimulation Page(s): 117.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines H-wave stimulation Page(s): 117.

**Decision rationale:** H-Wave is not recommended as an isolated intervention, but a one-month home-based trial of HWave stimulation may be considered as a noninvasive conservative option for diabetic neuropathic pain or chronic soft tissue inflammation if used as an adjunct to a program of evidence-based functional restoration, and only following failure of initially recommended conservative care, including recommended physical therapy (i.e., exercise) and medications, plus transcutaneous electrical nerve stimulation (TENS). In this case, there is no diagnosis of diabetic neuropathy or chronic soft tissue inflammation. There is no documentation of trial and failure of conservative management. Therefore, the request for H-wave is not considered medically necessary per guidelines.

#### **Multidisciplinary Evaluation for Functional Restoration Program: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Programs Page(s): 31-32.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Functional restoration program Page(s): 49.

**Decision rationale:** Functional restoration is an established treatment approach that aims to minimize the residual complaints and disability resulting from acute and/or chronic medical conditions. Functional restoration can be considered if there is a delay in return to work or a prolonged period of inactivity according to ACOEM Practice Guidelines, 2nd Edition, page 92. Functional restoration is the process by which the individual acquires the skills, knowledge and behavioral change necessary to avoid preventable complications and assume or re-assume

primary responsibility ("locus of control") for his/her physical and emotional well-being post injury. The individual thereby maximizes functional independence and pursuit of vocational and avocational goals, as measured by functional improvement. The following variables have been found to be negative predictors of efficacy of treatment with the programs as well as negative predictors of completion of the programs: (1) a negative relationship with the employer/supervisor; (2) poor work adjustment and satisfaction; (3) a negative outlook about future employment; (4) high levels of psychosocial distress (higher pretreatment levels of depression, pain and disability); (5) involvement in financial disability disputes; (6) greater rates of smoking; (7) duration of pre-referral disability time; (8) prevalence of opioid use; and (9) pre-treatment levels of pain. Criteria for the general use of multidisciplinary pain management programs: Outpatient pain rehabilitation programs may be considered medically necessary when all of the following criteria are met: (1) An adequate and thorough evaluation has been made, including baseline functional testing so follow-up with the same test can note functional improvement; (2) Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement; (3) The patient has a significant loss of ability to function independently resulting from the chronic pain; (4) The patient is not a candidate where surgery or other treatments would clearly be warranted (if a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits may be implemented to assess whether surgery may be avoided); (5) The patient exhibits motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change; & (6) Negative predictors of success above have been addressed. In this case, there is no documentation of a thorough assessment of negative predictors and there is no evidence of baseline functional testing. As such the above criteria are not met and thus the request is considered not medically necessary.

**Amrix ER 15mg, qty 60: Upheld**

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

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

**Decision rationale:** According to the guidelines, antispasmodics are used to decrease muscle spasms. Cyclobenzaprine is recommended as an option, using a short course. In this case, the medical records do not document the presence of substantial muscle spasm refractory to first line therapy. The medical records do not demonstrate the patient presented with exacerbation unresponsive to first-line interventions. There is no documentation of any significant improvement with prior use. Chronic use of muscle relaxants is not recommended by the guidelines. Thus, the medical necessity for Amrix ER is not established.

**Ibuprofen 400mg, qty 60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 111, 74.

**Decision rationale:** Per guidelines, Anti-inflammatories are the traditional first line of treatment, to reduce pain so activity and functional restoration can resume, but long-term use may not be warranted. A comprehensive review of clinical trials on the efficacy and safety of drugs for the treatment of low back pain concludes that available evidence supports the effectiveness of non-selective nonsteroidal anti-inflammatory drugs (NSAIDs) in chronic LBP. In this case, the records indicate that the IW has been taking Ibuprofen on chronic basis. However, there is no documentation of any significant improvement in pain level or function with continuous use. Therefore, the request is not considered medically necessary due to lack of documentation.

**Lidocaine 5% Ointment, qty 1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 112.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm Page(s): 56.

**Decision rationale:** According to the CA MTUS guidelines, Topical Analgesics "Lidocaine" is recommended for localized peripheral pain (i.e. post-herpetic neuralgia) after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as Gabapentin or Lyrica). The medical records do not document a diagnosis of neuropathic pain. Any other applications are considered off label and not approved. Thus, the request is not medically necessary according to the guidelines.

**Neurontin 300mg, qty 180:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epilepsy drugs Page(s): 17.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin Page(s): 16.

**Decision rationale:** According to the guidelines, an anti-epilepsy drug (AED), such as Gabapentin, is recommended for neuropathic pain (pain due to nerve damage). Gabapentin has been shown to be effective for treatment of post-herpetic neuralgia diabetic painful and painful polyneuropathy (i.e. diabetic neuropathy) and has been considered as a first-line treatment for neuropathic pain. The medical records do not establish the patient has neuropathic pain. There are no subjective complaints, correlative objective clinical findings, and/or corroborative Electrodiagnostic evidence to establish active neuropathy is present. There are no signs or symptoms of neuropathy. The medical necessity of Gabapentin has not been established under the guidelines.

**MRI Thoracic Spine without contrast: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 303-304. Decision based on Non-MTUS Citation Official Disability Guidelines - Treatment in Workers Compensation, Indications for Imaging.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Guidelines (ODG) Thoracic spine.

**Decision rationale:** According to the ODG, MRI is recommended in thoracic spine trauma with neurological deficits, uncomplicated back pain with red flag signs, or with radiculopathy after at least 1 month conservative therapy (sooner with severe progressive neurological deficit) or prior to surgery, or with myelopathy. In this case, there is no documentation of any red flag signs, progressive radiculopathy / myelopathy or plan for spinal surgery; the above criteria are not met. Thus the request is considered not medically necessary.

**DME: Thoracic Outlet Figure 8 Brace: Upheld**

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG), Shoulder.

**Decision rationale:** CA MTUS/ODG do not address the issue. Thoracic outlet syndrome (TOS) is one of the most controversial entrapment syndromes. As there are no quality epidemiological studies linking this disorder to work, the most commonly reported cause is congenital. The treatment includes conservative management with physical therapy. There is no recommendation of treatment with figure of 8 in the guidelines. Therefore, the request is considered not medically necessary and is not approved.

**MRI/MRA Bilateral Brachial Plexus: 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 for Workers' Compensation, online edition, Shoulder Section.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation (ODG), Shoulder.

**Decision rationale:** CA MTUS/ACOEM guidelines do not address the issue. Per ODG, Magnetic resonance imaging (MRI) and arthrography have fairly similar diagnostic and therapeutic impact and comparable accuracy, although MRI is more sensitive and less specific. Thoracic outlet syndrome (TOS) is one of the most controversial entrapment syndromes. There are no quality studies for the evaluation and treatments for TOS. Diagnosis is mostly clinical. Electrodiagnostic Studies are the only recommended test to confirm the diagnosis. There is no

recommendation of MRI/MRA for the diagnosis of TOS in the guidelines. Therefore, the request is considered not medically necessary per guidelines.

**Retrospective request for Urine Drug Screen, DOS 03/06/14: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Drug Testing Page(s): 43.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Urine drug screen Page(s): 43, 74.

**Decision rationale:** As per CA MTUS guidelines and ODG, urine drug screening is recommended to assess for the use or the presence of illegal drugs and to monitor compliance with prescribed substances. As per ODG, patients at "low risk" of addiction/aberrant behavior should be tested within six months of initiation of therapy and on a yearly basis thereafter. Patients at "moderate risk" for addiction/aberrant behavior are recommended for point-of-contract screening 2 to 3 times a year with confirmatory testing for inappropriate or unexpected results. Patients at "high risk of adverse outcomes may require testing as often as once a month. In this case, there is little information as to prior urine drug test and its result. There is no documentation of any aberrant behavior or drug diversion. There is no evidence of non-compliance with medications. Therefore, the request is not medically necessary and is not approved.