

<b>Case Number:</b>	CM14-0059148		
<b>Date Assigned:</b>	08/08/2014	<b>Date of Injury:</b>	11/13/2013
<b>Decision Date:</b>	10/15/2014	<b>UR Denial Date:</b>	04/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/29/2014

### 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 Occupational 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:

The applicant is a represented [REDACTED] employee who has filed a claim for chronic neck pain reportedly associated with an industrial injury of November 13, 2013. Thus far, the applicant has been treated with the following: Analgesic medications; muscle relaxants; topical compounds; transfer of care to and from various providers in various specialties; casting of right wrist fracture; and unspecified amounts of physical therapy. In a clinical progress note dated December 9, 2013, the applicant reported multifocal, neck, head, shoulder, wrist, and low back pain. The applicant developed derivative complaints of anxiety and depression, it was suggested. The applicant was diagnosis of cervical sprain, lumbar sprain, right wrist fracture, and lumbar strain. Urine drug testing, multiple x-rays, Flexeril, Norco, and physical therapy were endorsed while the applicant was placed off of work, on total temporary disability, for 45 days. In a Utilization Review Report dated April 1, 2014, the claims administrator denied a required for Flexeril, denied a request for omeprazole, approve a request for tramadol, denied various topical compounds, denied electrodiagnostic testing, denied cervical MRI imaging, denied lumbar MRI imaging, and denied physical therapy. On May 19, 2014, 12 sessions of physical therapy were sought with electrodiagnostic testing of the bilateral upper extremities, MRI imaging of the cervical spine, MRI imaging of the shoulder, MRI imaging of the right wrist, and MRI imaging of the lumbar spine. Flexeril, omeprazole, and tramadol were renewed. There was no mention of medication efficacy. The applicant had apparently received a shoulder corticosteroid injection. It was acknowledged that the applicant had completed 10 recent sessions of physical therapy. In a June 24, 2014 clinical progress note, the applicant reported multifocal 7/10 wrist, shoulder, neck, and low back pain with derivative complaints of insomnia, anxiety, and depression. It was stated that the applicant was status post wrist surgery. Well-preserved wrist range of motion was noted with limited right shoulder range of motion

appreciated. The applicant had had lumbar and cervical MRI, which demonstrated multilevel low-grade disk protrusions, it was suggested. A psychiatric consultation, internal medicine consultation, and electrodiagnostic testing of the upper extremities were sought while the applicant was placed off of work, on total temporary disability. Omeprazole, tramadol, and Flexeril were all apparently renewed. There was no explicit discussion of issues with reflux, heartburn, or dyspepsia, however. In a Medical-Legal Evaluation dated July 22, 2014, it was acknowledged that the applicant was no longer working owing to multifocal pain complaints. The applicant's wrist pain was still significant. The applicant also had shoulder, knee, and neck complaints, it was further noted. The medical-legal evaluator suggested occupational therapy and physical therapy for both the wrist and the lumbar spine.

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

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

**Flexeril (7.5mg, #90): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril, Amrix, Fexmid, generic available).

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

**Decision rationale:** As noted on page 41 of the MTUS Chronic Pain Medical Treatment Guidelines, the addition of cyclobenzaprine (Flexeril) to other agents is "not recommended." In this case, the applicant is using a variety of other oral and topical agents. Adding cyclobenzaprine or Flexeril to the mix is not recommended. Therefore, the request is not medically necessary.

**Omeprazole (20mg, #90): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Omeprazole, Proton Pump Inhibitors.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms, and Cardiovascular Risk topic. Page(s): 69.

**Decision rationale:** While page 69 of the MTUS Chronic Pain Medical Treatment Guidelines does note that proton pump inhibitors such as omeprazole are indicated in the treatment of NSAID-induced dyspepsia, in this case, however, the documentation on file fails to establish the presence of any active symptoms of reflux, heartburn, and/or dyspepsia, either NSAID-induced or stand-alone, which would support ongoing usage of omeprazole. Therefore, the request is not medically necessary.

**Topical Compound TGHOT (Tramadol 8%, Gabapentin 10%, Menthol 2%, Camphor 2%, and Capsaicin 0.05%) 180gm: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Medications. Decision based on Non-MTUS Citation Official Disability Guidelines: Use of TGHot Cream in the management of low Back Pain

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

**Decision rationale:** As noted on page 113 of the MTUS Chronic Pain Medical Treatment Guidelines, gabapentin, one of the primary ingredients in the compound in question, is not recommended for topical compound formulation purposes. Since one or more ingredients in the compound in question are not recommended, the entire is not recommended, per page 111 of the MTUS Chronic Pain Medical Treatment Guidelines. Therefore, the request is not medically necessary.

**Topical Compound FlurFlex (Flurbiprofen 10%, Cyclobenzaprine 10%) 180gm: Upheld**

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

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

**Decision rationale:** As noted on page 113 of the MTUS Chronic Pain Medical Treatment Guidelines, muscle relaxants such as cyclobenzaprine are not recommended for topical compound formulation purposes. Since one or more ingredients in the compound are not recommended, the entire compound is not recommended, per page 111 of the MTUS Chronic Pain Medical Treatment Guidelines. Therefore, the request is not medically necessary.

**Electromyogram (EMG) of the Bilateral Upper Extremities: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

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

**Decision rationale:** While the MTUS Guideline in ACOEM Chapter 8, Table 8-8, page 182 does recommend EMG testing to clarify diagnosis of nerve root dysfunction in cases of suspected disk herniation preoperatively before epidural steroid injection therapy, in this case, however, there is no evidence that the applicant is intent on pursuing any kind of invasive procedure based on the outcome of the EMG in question. There is no evidence that the EMG in question would influence the treatment plan. There was no evidence that the applicant was actively contemplating an invasive procedure such as an epidural steroid injection or cervical spine surgery, on or around the date the EMG in question was requested. Therefore, the request is not medically necessary.

### **Nerve Conduction Velocity (NCV) of the Bilateral Upper Extremities: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 269,279.

**Decision rationale:** While the MTUS Guideline in ACOEM Chapter 11, Table 11-6 does score EMG testing 4/4 in its ability to identify and define suspected carpal tunnel syndrome, in this case, however, the applicant already has an established diagnosis of right wrist fracture, it has been stated, treated with casting. The attending provider's documentation failed to outline the presence of any signs or symptoms suggestive or active issues with carpal tunnel syndrome, such as upper extremity paresthasias, positive provocative testing at the wrist, etc. It appears, thus, the attending provider is seemingly intent on performing routine NCV testing of the bilateral upper extremities with no intention of acting on the results of the same. As noted in the MTUS-adopted ACOEM Guidelines in Chapter 11, Table 11-7, page 272, routine usage of NCV testing for diagnostic evaluation purposes is "not recommended." Therefore, the request is not medically necessary.

### **An 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 and Upper Back (Acute & Chronic).

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

**Decision rationale:** As noted in the MTUS-adopted ACOEM Guidelines in Chapter 8, Table 8-8, page 182, MRI imaging of the cervical spine is recommended to validate a diagnosis of nerve root compromise, based on clear history and physical exam findings, in preparation for an invasive procedure. In this case, however, as with the many other diagnostic study requests, there was no evidence that the applicant was intent on acting on the results of the cervical MRI. There was no evidence that the applicant is a surgical candidate. It was further noted that the applicant appears to have had earlier cervical MRI imaging in March 2014 which was, in fact, essentially negative and revealed only low-grade disk bulges of uncertain clinical significance. Repeat MRI imaging is not, consequently, indicated. Therefore, the request is not medically necessary.

### **An MRI of the Lumbar Spine: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 12 Low Back Complaints (2007), page(s) 53; and on the Non-MTUS Official Disability Guidelines, Low Back - Lumbar & Toracic (Acute & Chronic).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304.

**Decision rationale:** As noted in the MTUS-adopted ACOEM Guidelines in Chapter 12, page 304, imaging studies should be reserved for cases in which surgery is being considered or red-flag diagnoses are being evaluated. In this case, there is no evidence that the applicant is actively considering or contemplating any kind of lumbar spine surgery. There is no evidence that the applicant carries any red-flag diagnoses such as fracture, tumor, infection, cauda equina syndrome, etc., involving the lumbar spine. It was not stated how the MRI in question would alter the treatment plan. Therefore, the request is not medically necessary.

**An MRI of the Right Shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208-209.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 214.

**Decision rationale:** As noted in the MTUS-adopted ACOEM Guidelines in Chapter 9, Table 9-6, page 214, routine usage of MRI imaging for evaluation purpose without surgical indication is "not recommended." As with the many other diagnostic testing requests, there is no evidence that the applicant is intent on acting on the results of the proposed shoulder MRI. There is no evidence that the applicant is actively considering or contemplating shoulder surgery. Therefore, the request is not medically necessary.

**An MRI of the Right Wrist:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 272.

**Decision rationale:** While the MTUS Guideline in ACOEM Chapter 11, Table 11-7, page 272 does acknowledge that usage of MRI prior to history and physical examination by qualified specialist is "optional," in this case, however, the applicant already has an established diagnosis of wrist fracture. The applicant has been treated with casting for the same, it has been suggested on several occasions. It is not clear how MRI of this would alter or influence the treatment plan as the applicant already has an established diagnosis of wrist fracture here. Therefore, the request is not medically necessary.

**Physical Therapy (12-sessions):** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints Page(s): 174, 203, Chronic Pain Treatment Guidelines Physical Medicine. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 12 Low Back Complaints (2007), page(s) 134.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99,88, 99.

**Decision rationale:** The 12-session course of physical therapy proposed, in and of itself, represents treatment in excess of the 9- to 10-session course recommended on page 99 of the MTUS Chronic Pain Medical Treatment Guidelines for myalgias and myositis of various body parts, the issue reportedly present here. This recommendation, it is further noted, is qualified by commentary made on page 8 of the MTUS Chronic Pain Medical Treatment Guidelines to the effect that there must be some demonstration of functional improvement at various milestones in the treatment program in order to justify continued treatment. In this case, however, the applicant is off of work, on total temporary disability. The applicant remains highly reliant and highly dependent on various oral and topical medications. All of the above, taken together, suggest a lack of functional improvement as defined in MTUS 9792.20f, despite earlier physical therapy in unspecified amounts over the course of the claim. Therefore, the request for 12 additional sessions of physical therapy is not medically necessary.