

Case Number:	CM14-0188835		
Date Assigned:	11/21/2014	Date of Injury:	03/27/2014
Decision Date:	01/20/2015	UR Denial Date:	10/22/2014
Priority:	Standard	Application Received:	11/12/2014

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, has a subspecialty in Interventional Spine 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 patient is a 46 year old female with an injury date of 3/27/14. Work status as of 9/17/14: return to full duty. Pain decreases with rest; uses medications as need and pain decreases to 4/10. The patient reports 4/10 pain in the cervical spine/left shoulder/right foot and 5/10 pain in the lumbar spine. Exam reveals increased range of motion (ROM) with impingement except left shoulder; with decreased abduction and internal rotation. The exam also reveals positive paraspinal SH, upper Trap in tenderness, positive Kemp's bilaterally, decreased shoulder range of motion and decreased abduction; negative straight leg test, bilaterally. The 8/01/14 MRI of left shoulder showed acromioclavicular osteoarthritis, supraspinatus tendinitis, infraspinatus tendinitis, and bicipital tenosynovitis. The 6/27/14 MRI of cervical spine revealed early disc desiccation through the cervical spine and at C5-6 diffuse disc protrusion effacing the thecal sac, and C6 exiting nerve roots are unremarkable. The diagnoses include cervical sprain/strain, cervical intervertebral disc without myelopathy; lumbar sprain/strain, lumbar intervertebral disc without myelopathy; left shoulder - acromioclavicular osteoarthritis/tendinosis; right foot pain; and sexual dysfunction. The utilization review being challenged is dated 10/22/14. The provider requests the following: creams prescribed (unspecified), retrospective chromatography urinalysis, DOS 9/17/14, Prilosec 20mg # 30, Flexeril 5mg # 30, shockwave therapy one to two times a week for four weeks (8) for left shoulder, right foot/ankle, neck, and lumbar, IM consult, neuro spine evaluation for neck and lumbar, ortho initial consultation for right foot/ankle, ortho initial consultation for left shoulder, and chiropractic treatment twice a week for four weeks to left shoulder, right foot/ankle, neck and lumbar. The requesting provider has provided various reports from 5/22/14 to 10/21/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Creams prescribed (no other information available): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111.

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

Decision rationale: The provider requests creams prescribed (unspecified) per the 9/17/14 report. MTUS guidelines state topical analgesics are "largely experimental in use," but recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Many agents are compounded as mono therapy or in combination for pain control. But, there is little to no research to support its use. Regarding topical NSAIDs, use is indicated to joints that are amenable to topical treatment, while there is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Furthermore, it is an imperative that use of compounded agents requires knowledge of the specific analgesic effect of each agent and how it will be useful for the specific therapeutic goal required. The provider's request for prescribed "unspecified" creams, without specifics of each agent and its therapeutic goal, and given the lack of objective assessment and documentation of pain and function, and response to medication, cannot be deemed a medical necessity. The request is not medically necessary.

Retrospective: Chromatography urinalysis (DOS 9/17/14): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) Chapter, Urine drug testing (UDT) section

Decision rationale: The provider requests retrospective chromatography urinalysis, DOS 9/17/14. Official Disability Guidelines state that chromatography/mass spectrometry (GM/MS) or liquid chromatography mass spectrometry (LC/MS/MS) are considered confirmatory tests, and particularly important when results of a test are contested. Confirmation should be sought for (1) all samples testing negative for prescribed drugs, (2) all samples positive for non-prescribed opioids, and (3) all samples positive for illicit drugs. Per the 8/13/14 UA results, "No drugs were detected, and no drugs were expected." Per the 9/17/14 report, a UA was performed and to be continued to be performed, for "both prescribed medication management purposes as well as the monitoring of the patient to ensure that there is no illicit drug use." Given the lack of documentation from submitted records of aberrant drug-related/drug-seeking behaviors by this patient or that she has issues with or a history of drug addictions or drug abuse, confirmatory tests are not a medical necessity, given this patient is compliant with the routine POC urinalysis.

Furthermore, there is no documentation of on-going opioid treatment/contract with this patient. The request is not medically necessary.

Prilosec 20mg # 30: 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)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms & Cardiovascular Risk Page(s): 68-69.

Decision rationale: The provider requests Prilosec 20MG # 30 per the 9/17/14 report. Regarding PPI's, MTUS page 69, supports prophylactic use with NSAIDs for age older than 65, history of peptic ulcer, GI bleeding or perforation; concurrent use of ASA, corticosteroids, and or/an anticoagulants; or high dose/multiple NSAID. However, clinicians should weigh indications for NSAIDs against both GI and cardiovascular risk factors, determining if the patient is at risk for gastrointestinal events. It is unknown when this patient began this medication. In the 7/30/14 AME report, there is a reference to a 4/18/14 report that Omeprazole, Cyclobenzaprine, and Naproxen Sodium are prescribed, as well as transdermal compounds including Flurbiprofen/Tramadol/Cyclobenzaprine 20/20/4%, Amitriptyline/Dextromethorphan Gabapentin cream 10/10/10%, and Menthoderm gel are also prescribed. Additionally, review of the 9/17/14 report do not indicate concurrent use of ASA, corticosteroids and/or anticoagulants, or high-dose multiple NSAIDs. Given the absence of documentation of a GI or cardiovascular risk assessment conducted for this patient, continued Prilosec use is not a medical necessity. The request is not medically necessary.

Flexeril 5mg #30: 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 Flexeril; Muscle Relaxants Page(s): 41-42; 63-64.

Decision rationale: The provider requests Flexeril 5MG # 30 per the 9/17/14 report. According to MTUS guidelines, use of Cyclobenzaprine (Flexeril) is recommended as an option, using a short course of therapy as an antispasmodic or anti-spasticity drug, brief post-operative use, or patients with fibromyalgia. In most low back pain cases, they show no benefit beyond NSAIDs in pain and overall improvement and efficacy appears to diminish over time. It is unknown when this patient was first prescribed Flexeril, or for how long, as there is an absence of documentation of current medications both prescribed and taken. In the 7/30/14 AME report, there is a reference to a 4/18/14 report that Omeprazole, Cyclobenzaprine, and Naproxen Sodium are prescribed, as well as transdermal compounds including Flurbiprofen/Tramadol/Cyclobenzaprine 20/20/4%, Amitriptyline/Dextromethorphan Gabapentin cream 10/10/10%, and Menthoderm gel are also prescribed. The provider also does not document why this patient requires Flexeril as a medical necessity as opposed to taking oral NSAIDs, which provides comparable levels of analgesia per

MTUS guidelines and shows no benefit beyond NSAIDs in most low back pain cases. Furthermore, there is no objective documentation of assessment and outcome from the use of Flexeril and function/activity achieved. The request is not medically necessary.

Shockwave therapy one to two times a week for four weeks (8) for left shoulder, right foot/ankle, neck and lumbar: 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 Official Disability Guidelines (ODG) Elbow (Acute and Chronic) Chapter, ESWT

Decision rationale: The patient reports she "still continues to have significant residual symptoms." This patient underwent extensive conservative care to the lower back, including but not limited to: physical and manipulating therapy, acupuncture, injections and prescribed medications. Per the 9/17/14 report, patient reports pain level of 4-5/10 which decreases with rest. The provider requests shockwave therapy one to two times a week for four weeks (8) for left shoulder, right foot/ankle, neck, and lumbar per the 9/17/14 report. Official Disability Guidelines do not recommend the use of Extracorporeal Shock Wave Therapy (ESWT), however, if the decision is made to use this treatment despite the lack of convincing evidence: (1) Patients whose pain from lateral epicondylitis (tennis elbow) has remained despite six months of standard treatment. (2) At least three conservative treatments have been performed prior to use of ESWT. These would include: (a) Rest; (b) Ice; (c) NSAIDs; (d) Orthotics; (e) Physical Therapy; (e) Injections (Cortisone). (3) Contraindicated in Pregnant women; Patients younger than 18 years of age; Patients with blood clotting diseases, infections, tumors, cervical compression, arthritis of the spine or arm, or nerve damage; Patients with cardiac pacemakers; Patients who had physical or occupational therapy within the past 4 weeks; Patients who received a local steroid injection within the past 6 weeks; Patients with bilateral pain; Patients who had previous surgery for the condition. (4) Maximum of 3 therapy sessions over 3 weeks. Per the 10/21/14 report, this patient underwent the fourth treatment of ECSWT treatment and reported "measurable improvement in pain," however, no objective documentation was provided regarding function and pain levels after treatment. More importantly, shockwave therapy is not recommended for neck and lumbar condition. The request is not medically necessary.

Internal Med Evaluation: 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)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: AETNA, Clinical Policy Bulletin: Female Sexual Dysfunction (FDS), Policy Number: 0574

Decision rationale: The patient sustained a cumulative trauma injury, dated 3/27/14, which "also caused sleep disorder, sexual dysfunction, and psyche problems," according to the 7/30/14 Agreed Medical Examination (AME) Preliminary Report, referencing the 3/27/14 Application for Adjudication of Claim report. The provider requests an IM consult for sexual dysfunction per the 9/17/14 report. According to AETNA, if a specific etiology for female sexual dysfunction (FSD) is discovered on history, physical, and laboratory examination, the suspected etiology may be treated. If no specific etiology for FSD is discovered, basic treatment strategies are applied. These include educational interventions, enhancement of stimulation and elimination of routine (e.g., use of erotic books or videos, varying positions, use of vibrators, etc.), provision of distraction techniques (e.g., background music, encourage fantasies, etc.), encouragement of non-coital behaviors (e.g., sensate focus exercises, sensual massage), and techniques to minimize dyspareunia (e.g., change in position, topical Lidocaine, lubricants, etc.). Referenced in the 7/30/14 AME report, patient "developed sexual dysfunction from 12/18/11 through 3/27/14" and attributes the onset of her symptoms to performing the "strenuous and repetitive nature of her job duties." While the patient reports the sexual dysfunction is attributed to her work injury, there is an absence of a comprehensive and diagnostic workup, in conjunction with lab tests to by the provider to confirm/rule out the etiology of. A referral request for an IM consult is premature, given the lack of documented history, physical, and laboratory examination of the patient as related to FDS, and cannot be warranted a medical necessity. The request is not medically necessary.

Neurospine evaluation for neck and lumbar: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306. 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) ACOEM, Chapter 7, Consultations, page 127

Decision rationale: This patient presents with 4/10 pain in the cervical spine and left shoulder and 5/10 pain in the lumbar spine. The provider requests neurospine evaluation for neck and lumbar per the 9/17/15 report. ACOEM guidelines state, "A referral may be for consultation to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work. A consultant is usually asked to act in an advisory capacity, but may sometimes take full responsibility for investigation and/or treatment of an examinee or patient." The patient's injury was sustained on 3/27/14 but patient has already been cleared to return to full duty on 9/17/14. The patient denies radiating pain or numbness/tingling of the upper extremity/lower extremity. The 10/21/14 cervical spine exam shows normal/active: flexion of 50/45, extension of 60/49, right and left rotation of 80/70, and right/left lateral flexion of 45/45. This patient's subjective report of mild, non-radicular/radiating pain and the lack of clinical or objective documentation fail to adequately support a neurospine consultation as a medical necessity. Furthermore, the patient is able to participate in activities of daily living (ADLs) and does not appear to have documentation of having sustained major/minor permanent residual loss. The request is not medically necessary.

Orthopedic initial consultation for right foot/ankle: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 127. 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) ACOEM, Chapter 7, Consultations, page 127

Decision rationale: This patient reports constant, mild pain in the right foot of 4/10. The provider requests orthopedic initial consultation for right foot/ankle per the 9/17/14 report. ACOEM guidelines state, "A referral may be for consultation to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work. A consultant is usually asked to act in an advisory capacity, but may sometimes take full responsibility for investigation and/or treatment of an examinee or patient." This patient has already been cleared to return to full duty on 9/17/14. Pain is reported at 4/10 with use of medications as needed and decreases in pain with resting. The patient denies any radicular or radiating pain to the lower extremities, and denies having any tingling or numbness of lower extremities. According to the 10/21/14 progress report, exam showed 5/5 lower extremity motor strength bilaterally, with: hip flexion, psoas (L1-3), knee extension, quadriceps (L2-4), foot dorsiflexion, tibialis anterior (L4-5), first toe extension, ext. hallucis, longus (L5), knee flexion, hamstrings (L4-S1), foot inversion, tibialis anterior/posterior (L4-5), foot eversion, peroneus longus/brevis (S1), and foot plantar flexion, gastrocnemius/soleus (S1). Also, patient had negative straight leg test, bilaterally per the 9/17/14 report. Given this patient's clearance to return to full duty as of 9/17/14, the lack of documentation in reviewed records of the need for a right foot consult when exam results are within normal limits and patient is not limited in mobility or activity, the request cannot be warranted a medical necessity. The request is not medically necessary.

Orthopedic initial consultation for left shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 127. 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) ACOEM, Chapter 7, Consultations, page 127

Decision rationale: This patient reports constant, mild cervical pain and lumbar pain, rated at 4-5/10. The provider requests orthopedic initial consultation for left shoulder per the 9/17/14 report. ACOEM guidelines state, "A referral may be for consultation to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work. A consultant is usually asked to act in an advisory capacity, but may sometimes take full responsibility for investigation and/or treatment of an examinee or patient." This patient has already been cleared to return to full duty on

9/17/14. Pain is reported at 4/10 with use of medications as needed and decrease in pain with resting. Patient denies any radicular or radiating pain to the upper extremities, and denies having any tingling or numbness of the upper extremities. According to the 10/21/14 progress report, exam showed 5/5 bilateral upper extremity motor strength with: shoulder abduction, deltoid (C5), arm flexion, biceps (C5-6), shoulder internal rotation, subscapularis (C5-6), shoulder external rotation, infraspinatus, Teres minor (C5-T1), wrist extension, extensor carpi (C6), wrist flexion, flexor carpi (C7), finger extension, extensor digitorum (C7), finger flexion, flexor digitorum (C8), and finger adduction, interossei (T1). Given this patient's clearance to return to full duty as of 9/17/14, the lack of documentation in reviewed records of the need for a left shoulder consult when exam results are within normal limits, and patient is not limited in activities of daily living (ADLs), the request cannot be warranted a medical necessity. The request is not medically necessary.

Chiropractic treatment twice a week for four weeks to left shoulder, right foot/ankle, neck and lumbar: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints Page(s): 203, 173, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Treatments Page(s): 58-59.

Decision rationale: This patient reports constant, mild cervical pain and lumbar pain of 4-5/10. The provider requests chiropractic treatment twice a week for four weeks to left shoulder, right foot/ankle, neck and lumbar per the 9/17/14 report. For chiropractic treatments, MTUS guidelines allow up to 18 sessions total and 1-2 sessions every 4-6 months if the patient is working. The goal is to "reduce the frequency of treatments to the point where maximum therapeutic benefit continues to be achieved while encouraging more active self-therapy, such as independent regimens. Elective/maintenance care is not medically necessary. Not recommended for the ankle and foot. Based on the 10/21/14 report, this patient reported "activity of daily living improvements and physio/chiropractic providing relief." The patient denied any difficulties with activities of daily living (ADLs) and none were noted. The 10/21/14 cervical spine exam showed normal/active: flexion of 50/45, extension of 60/49, right and left rotation of 80/70, and right/left lateral flexion of 45/45. Exam also showed full upper extremity/lower extremity motor strength, with no deficits. The progress was documented as "plateaued, no further improvement is expected for this patient at this time." According to the work status as of 9/17/14, the patient was to return to full duty and her progress has "plateaued with no further improvement is expected" and no difficulties noted with ADLs according to the 10/21/14 providers report. Furthermore, an additional 8 chiropractic sessions over a period of 4 weeks exceeds MTUS guidelines and cannot be considered a medical necessity, given the patient has achieved and increased activity independence; also, chiropractic treatment is not recommended for the ankle and foot. The request is not medically necessary.