

<b>Case Number:</b>	CM14-0195401		
<b>Date Assigned:</b>	12/02/2014	<b>Date of Injury:</b>	09/21/2014
<b>Decision Date:</b>	04/22/2015	<b>UR Denial Date:</b>	11/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/20/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 27-year-old female with an injury date of 09/21/14. Based on the 11/03/14 progress report provided by treating physician, the patient complains of neck pain, back pain that radiates to left lower extremities and left shoulder pain. Physical examination to the cervical spine on 11/03/14 revealed tenderness to palpation and spasm with decreased range of motion and positive compression test. Examination to the thoracic spine revealed tenderness to palpation, spasm and trigger points with decreased range of motion. Examination to the lumbar spine revealed tenderness to palpation and spasm with decreased range of motion. Straight leg raise test positive on the left at 30 degrees. Decreased motor strength to left lower extremity at 4/5. Examination to the left shoulder revealed tenderness to palpation with decreased range of motion. Decreased motor strength to left shoulder at 4/5. Decreased sensation to left shoulder, arm, forearm, hand, thigh, knee, leg and foot. Positive Neer's, Codman's and Supraspinatus tests. Patient's medications include Tramadol, Naproxen and Medrol. Patient has been prescribed Cyclobenzaprine #60 on 11/03/14. The patient is temporarily totally disabled per treater's report 11/03/14. Diagnosis 11/03/14; Cervical Musculoligamentous Strain/Sprain, Acute with Radiculitis. Rule Out Cervical Spine Discogenic Disease. Thoracic Musculoligamentous Strain/Sprain. Lumbosacral Musculoligamentous Strain/Sprain with Radiculitis. Rule Out Lumbosacral Spine Discogenic Disease. Bilateral Shoulder Strain/Sprain versus Cervical Radiculitis. The utilization review determination being challenged is dated 11/19/14. The rationale is "Recommended as an option using a short course of therapy." Treatment reports were provided from 09/25/14 to 11/03/14.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Lumbosacral brace:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) low back chapter, lumbar supports.

**Decision rationale:** This patient presents with neck, back, and shoulder complaints. The current request is for lumbosacral brace. ACOEM Guidelines page 301 on lumbar bracing state, "Lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief." ODG Guidelines under its low back chapter, lumbar supports states, "Prevention: Not recommended for prevention. There is strong and consistent evidence that lumbar supports were not effective in preventing neck and back pain." Under treatment, ODG further states, "Recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific LBP (very low-quality evidence, but may be a conservative option)." There was no rationale provided for the request. In this case, the patient is diagnosed with lumbar strain with radiculitis and does not present with fracture, spondylolisthesis, or documented instability to warrant lumbar bracing. For nonspecific low back pain, there is very low-quality evidence. The requested low back brace IS NOT medically necessary.

**Interferential unit/hot and cold unit to lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118 - 120. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter, continuous-flow cryotherapy.

**Decision rationale:** This patient presents with neck, low back, and bilateral shoulder complaints. The current request is for interferential unit/hot and cold unit to lumbar spine. For Interferential Current Stimulation (ICS), MTUS guidelines, pages 118 - 120, state that "Not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone." These devices are recommended in cases where: (1) Pain is ineffectively controlled due to diminished effectiveness of medications; or (2) Pain is ineffectively controlled with medications due to side effects; or (3) History of substance abuse; or (4) Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or (5) Unresponsive to

conservative measures (e.g., repositioning, heat/ice, etc.). The medical file provided for review includes no documentation of substance abuse, operative condition, or unresponsiveness to conservative measures to warrant an IF unit trial. Furthermore, MTUS requires a 30-day trial of the unit showing pain and functional benefit before a home unit is allowed. For the cold/hot unit, the MTUS and ACOEM guidelines do not discuss cold/hot therapy units. Therefore, ODG Guidelines are referenced. ODG Guidelines has the following regarding continuous-flow cryotherapy: "Recommended as an option after surgery but not for nonsurgical treatment. Postoperative use generally may be up to 7 days including home use. In the postoperative setting, continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic use. However, the effectiveness on more frequently treated acute injuries has not been fully evaluated." ODG does not recommend continuous-flow cryotherapy for nonsurgical treatment. In this case, there is no documentation of a 30 day trial of an IF unit and here is no indication of recent or projected surgery for the cold/hot unit. The requested IF/hot and cold unit IS NOT medically necessary.

**Physical Therapy 2 x 6 sessions for lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 98-99.

**Decision rationale:** This patient presents with neck, low back, and bilateral shoulder complaints. The current request is for physical therapy 2 x 6 sessions for the lumbar spine. For physical medicine, the MTUS Guidelines page 98 and 99 recommends for myalgia and myositis type symptoms 9 to 10 visits over 8 weeks. Review of the medical file does not indicate that the patient has trialed physical therapy. Given the patient's continued complaints of pain and decreased range of motion, a course of 9 to 10 sessions is warranted. The treater's request for 12 initial sessions exceeds what is recommended by MTUS. This request IS NOT medically necessary.

**Functional Capacity exam:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 137-138.

**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 Guidelines, Chapter: 7, pages 137 and 139.

**Decision rationale:** This patient presents with neck, low back, and bilateral shoulder complaints. The current request is for functional capacity exam. The treating physician states that the exam is to "Ensure this patient can safely meet the physical demands of their occupation." ACOEM Guidelines, pages 137 and 139 do not support routine use of functional capacity evaluation. It states that the examiner is responsible for determining whether the impairment results in functional limitation. There is little evidence that FCEs can predict an

individual's actual capacity to perform in the workplace. FCEs are reserved for special circumstances when the employer or adjuster request for it, or if the information from FCEs is crucial. A routine FCE is not supported, and the treating physician is requesting on "to determine work capabilities." In this case, there is no information in the medical records provided to indicate that the employer or adjuster has requested a functional capacity evaluation. This request IS NOT medically necessary.

**Compound NPC1: Gabapentin 10%/ Amitriptyline 10%/Bupivacaine 5% in cream base 210gm: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines topical creams, Topical analgesics Page(s): 111.

**Decision rationale:** This patient presents with neck, low back, and bilateral shoulder complaints. The current request is for a compound NPCI: gabapentin 10%, amitriptyline 10%, bupivacaine 5%, and cream base 210 g. The MTUS Guidelines page 111 has the following regarding topical creams, "Topical analgesics are largely experimental and used with few randomized controlled trials to determine efficacy or safety." MTUS states that many agents are compounded for pain control including antidepressants and that there is little to no research to support their use. MTUS further states, "Any compounded product that contains at least one (or drug class) that is not recommended is not recommended." MTUS specifically states that antidepressants such as Amitriptyline are not recommended. In addition, Gabapentin is also not recommended in any topical formulation. The requested compound cream IS NOT medically necessary.

**Compound MPHCC1: Flurbiprofen 20%/ Baclofen 5%/ Dexamethasone 2%/ Menthol 2%/ Camphor 2%/ Capsaicin 0.025% in cream base 210: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines topical creams, topical analgesics Page(s): 111.

**Decision rationale:** This patient presents with neck, low back, and bilateral shoulder complaints. The current request is for compound MPHCCI: flurbiprofen 20%, baclofen 5%, dexamethasone 2%, menthol 2%, camphor 2%, capsaicin 0.025%, and cream base 210. The MTUS Guidelines p 111 has the following regarding topical creams, "topical analgesics are largely experimental and used with few randomized control trials to determine efficacy or safety." MTUS further states, "Any compounded product that contains at least one (or drug class) that is not recommended is not recommended." For Flurbiprofen, which is a nonsteroidal anti-inflammatory agent, "the efficacy in clinical trials for this treatment modality has been inconsistent, and most studies are small and of short duration. Indications for use are

osteoarthritis and tendinitis (in particular, that of the knee and elbow) or other joints that are amendable to topical treatment." In this case, the patient does not meet the indication for this topical medication as he does not present with osteoarthritis or tendinitis symptoms but suffers from chronic neck, back and shoulder pain. This topical compound medication IS NOT medically necessary.

**Ibuprofen 800mg:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, 67-73.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain; Anti-inflammatory medications Page(s): 60, 61; 22.

**Decision rationale:** This patient presents with neck, low back, and bilateral shoulder complaints. The current request is for ibuprofen 800 mg. Treatment report dated 11/03/2014 indicates that this is a request for ibuprofen 800 mg #90. The utilization review denied the request stating, "NSAIDs are recommended for only short-term use. No exceptional circumstances were evident in this case." For anti-inflammatory medications, the MTUS Guidelines page 22 states, "Anti-inflammatory 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." Report 11/3/14, made an initial request for this medication. MTUS supports the use of NSAID as a first line of treatment for pain and inflammation. The requested Ibuprofen IS medically necessary.

**Cyclobenzaprine 100mg:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril).

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

**Decision rationale:** The patient presents with neck pain, back pain that radiates to left lower extremities and left shoulder pain. The request is for CYCLOBENZAPRINE 100MG. Patient diagnosis on 11/03/14 included cervical, thoracic, lumbar and shoulder strain/sprain. X-ray of the cervical spine shows unremarkable C-spine study. Patient's medications include Tramadol, Naproxen and Medrol. The patient is temporarily totally disabled per treater's report 11/03/14. MTUS pg 63-66 states: "Muscle relaxants (for pain): Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbation in patients with chronic LBP. The most commonly prescribed antispasmodic agents are carisoprodol, cyclobenzaprine, metaxalone, and methocarbamol, but despite their popularity, skeletal muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions. Cyclobenzaprine (Flexeril, Amrix, Fexmid, generic available): Recommended for a short course of therapy." Treater has not provided reason for the request, nor indicated quantity. MTUS only recommends short-term use (no more than 2-3 weeks) for sedating muscle relaxants. Patient has already been prescribed Cyclobenzaprine 10mg #60 on 11/03/14. The request for additional Cyclobenzaprine, unspecified quantity would exceed MTUS recommendation and does not indicate intended short-term use. Therefore the request IS NOT medically necessary.