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| <b>Case Number:</b>   | CM14-0200115 |                              |            |
| <b>Date Assigned:</b> | 12/10/2014   | <b>Date of Injury:</b>       | 09/15/2014 |
| <b>Decision Date:</b> | 01/28/2015   | <b>UR Denial Date:</b>       | 10/31/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 12/01/2014 |

### 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 Internal Medicine and is licensed to practice in New York. 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 claimant is a 22 yo female who sustained an industrial injury on 09/15/2014. The mechanism of injury was not provided for review. Her diagnoses include lumbosacral musculoligamentous strain/sprain with radiculitis, rule out lumbosacral discogenic disease, bilateral shoulder strain/sprain, bilateral shoulder impingement, bilateral elbow strain/sprain, bilateral elbow epicondylitis, bilateral wrist strain/sprain, rule out bilateral carpal tunnel syndrome, bilateral wrist overuse syndrome, bilateral knee strain/sprain and bilateral platar fasciitis. She continues to complain of low back pain, bilateral upper extremity pain, bilateral knee/leg pain, and bilateral ankle/foot pain. On physical exam there is lumbar paraspinal muscle pain to palpation, pain over the sciatic notches and decreased range of lumbar range of motion. Straight leg raise is positive bilaterally. There is decreased range of motion of the shoulders with positive Neer bilaterally and positive Codman's on the right. Knee exam reveals positive McMurray's test bilaterally. Treatment has included medical therapy with topical compounded medications. The treating provider has requested Physical therapy 2 x 6 to lumbar, bilateral shoulders, bilateral elbows, bilateral knees, and bilateral ankles, physical performance FCE, EMG/NCV bilateral upper extremities, Hot and Cold Unit, Interferential Unit, Lumbosacral Brace, and Compound medications: a) Gabapentin 10%, Amitriptyline 10%, Bupivacaine 5% in cream base; 210 grams b) Flurbiprofen 20%, Baclofen 5%, Dexamethasone 2%, Menthol 2%, Camphor 2%, Capsaicin 0.025% in cream base; 210 grams.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy x 6 to lumbar, bilateral shoulders, bilateral elbows, bilateral knees, and bilateral ankles:** 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) and ACOEM Pain, Suffering, and the Restoration of Function Chapter, pg. 114

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

**Decision rationale:** Per California MTUS Treatment Guidelines 2009, physical therapy is indicated for the treatment of musculoskeletal pain. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. Evidence based guidelines support up to 6 visits. In this case the requested physical therapy exceeds guidelines for an initial trial. The guidelines stress the importance of a time-limited treatment plan with clearly defined functional goals. Monitoring from the treating physician regarding progress and continued benefit of treatment is paramount. Medical necessity for the requested physical therapy sessions has not been established. The requested service is not medically necessary.

**Physical performance FCE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 48. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness For Duty Chapter

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Functional Capacity Evaluation (FCE) Page(s): 125-126.

**Decision rationale:** There is no documentation provided necessitating a FCE. A FCE may be required showing consistent results with maximal effort, demonstrating capacities below an employer verified physical demands analysis. There is little scientific evidence confirming that FCEs predict an individual's actual capacity to perform in the work place, an FCE reflects what an individual can do on a single day, at a particular time, under controlled circumstances that provide an indication of that individual's abilities. It is medically reasonable to first determine work restrictions and limitations based on clinical examination. Medical necessity for the requested service has not been established. The requested service is not medically necessary.

**EMG/NCV bilateral upper extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back Chapter

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (ODG) Indications for EMG/NCV testing 2010

**Decision rationale:** There is no documentation provided necessitating bilateral EMG/NCV testing of the upper extremities. Per the medical documentation the claimant's clinical findings of upper extremity numbness involve only the right elbow and right hand. There are no clinical signs of carpal tunnel syndrome. EMG and nerve conduction studies are an extension of the physical examination. They can be useful in aiding in the diagnosis of peripheral nerve and muscle problems. This can include peripheral neuropathies, entrapment neuropathies, radiculopathies, and muscle disorders. Per the Official Disability Guidelines, EMG studies are only recommended in patients with clinical signs of carpal tunnel syndrome who may be candidates for surgery. Electrodiagnostic testing includes testing for nerve conduction velocities but the addition of electromyography is generally not necessary. There is no specific documentation of subjective/objective findings consistent with radiculopathy or nerve entrapment. In addition, there is no documentation of failure of conservative treatment. There is no specific indication for bilateral EMG/NCV of the bilateral upper extremities. Medical necessity for the requested service has not been established. The requested service is not medically necessary.

**Hot and Cold Unit:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation PubMed indexed for Medline

**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: Medscape Internal Medicine Treatment of Low Back Pain 2012

**Decision rationale:** Per Medscape Internal Medicine, heat/cold therapy is recommended as an option in the treatment of low back pain. The documentation does not indicate that the claimant found objective benefit with the use of a heat/cold therapy. Medical necessity for the requested item has not been established. The recommended service is not medically necessary.

**Interferential Unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 114, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 118-120.

**Decision rationale:** Per MTUS guideline, Interferential Current Stimulation ( ICS) is 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. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and post-operative knee pain. The findings from these trials were either negative or non-interpretible for recommendation due to poor study design and/or methodological issues. There are no standardized protocols for the use of interferential therapy; and the therapy may vary according to the frequency of stimulation, the pulse duration, treatment time, and electrode-placement technique. Possibly appropriate for the following conditions if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine: - Pain is ineffectively controlled due to diminished effectiveness of medications; or - Pain is ineffectively controlled with medications due to side effects; or - History of substance abuse; or - Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or - Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). If those criteria are met, then a one-month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction. A "jacket" should not be certified until after the one-month trial and only with documentation that the individual cannot apply the stimulation pads alone or with the help of another available person. There is no specific documentation that the patient has been unresponsive to conservative measures. Medical necessity for the requested item has not been established. The requested item is not medically necessary.

**Lumbosacral Brace:** Upheld

**Claims Administrator 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

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

**Decision rationale:** There is no indication for a lumbosacral brace. Per ODG back bracing is indicated for the following conditions: compression fracture, spondylolisthesis, instability, or post-operative treatment. The documentation indicates the claimant has subjective back pain and objective evidence of paraspinal muscle tenderness, sciatic notch tenderness and paraspinal muscle spasm. There is no documentation of a condition/diagnosis with supportive subjective and objective findings for which a back brace is supported by the guidelines. Medical necessity for the requested item has not been established. The requested item is not medically necessary.

**Compound medications:** a) Gabapentin 10%, Amitriptyline 10%, Bupivacaine 5% in cream base; 210 grams b) Flurbiprofen 20%, Baclofen 5%, Dexamethasone 2%, Menthol 2%, Camphor 2%, Capsaicin 0.025% in cream base; 210 grams: Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 111, 112-113.

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

**Decision rationale:** There is no documentation provided necessitating use of the requested topical medication. Per California MTUS Guidelines topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied topically to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. Many agents are compounded as monotherapy or in combination for pain control (including NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, alpha-adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists,  $\gamma$  agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor) Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. In this case there have been no studies of topical formulations of Gabapentin and Amitriptyline for the treatment of chronic musculoskeletal pain. Medical necessity for the requested item has not been established. The requested treatment is not medically necessary.