

<b>Case Number:</b>	CM14-0205260		
<b>Date Assigned:</b>	01/30/2015	<b>Date of Injury:</b>	03/21/2014
<b>Decision Date:</b>	03/09/2015	<b>UR Denial Date:</b>	12/05/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/08/2014

### 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: Texas, Ohio, California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

### 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, mid back, and low back pain reportedly associated with an industrial injury of March 21, 2014. In a utilization review report dated December 5, 2014, the claims administrator failed to approve requests for a hot and cold therapy unit, an orthopedic evaluation, physical therapy, weekly toxicology testing, a home exercise rehabilitation kit, Naprosyn, Prilosec, Flexeril, and electrodiagnostic testing. The applicant's attorney subsequently appealed. On January 8, 2015, the applicant reported right arm, right shoulder, and mid back pain, Paresthesias about the right hand were evident. The applicant was not having any lower extremity pain, it was acknowledged. MRI imaging of the cervical spine demonstrated a C5-C6 protrusion/bulge with other discs intact. MRI imaging of the right shoulder demonstrated a possible supraspinatus tendon tear. MRI imaging of the thoracic spine demonstrated degenerative changes. On January 8, 2015, the attending provider noted that electrodiagnostic testing of the bilateral upper extremities was normal. The applicant had not worked since the date of injury, it was acknowledged. No lower extremity pain was evident. Right shoulder, right arm, and mid back pain were evident. Epidural steroid injection therapy was sought. The applicant was placed off of work, on total temporary disability. The applicant had received various treatments, including electrical stimulation, myofascial release therapy, infrared therapy, and ultrasound therapy at various points in 2014, including in June and July 2014. On October 31, 2014, acupuncture, cervical traction system, manipulative therapy, a heat and cold therapy unit, a rehabilitation kit, electrodiagnostic testing of the cervical spine, thoracic spine, shoulder, elbow, a neurosurgeon

versus orthopedic evaluation for the shoulder and elbow, physical therapy, toxicology testing, Naprosyn, Prilosec, and Flexeril were endorsed while the applicant was kept off of work, on total temporary disability. Ongoing complaints of neck pain, mid back pain, right shoulder pain, and right elbow pain were reported.

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

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

#### **Six Acupuncture Visits: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** The request is a renewal request for acupuncture. While the Acupuncture Medical Treatment Guidelines in MTUS 9792.24.1.d acknowledges that acupuncture treatments may be extended if there is evidence of functional improvement as defined in Section 9792.20(f), in this case, however, there was/is no evidence of functional improvement. The applicant was/is off of work, on total temporary disability, despite completion of earlier unspecified amounts of acupuncture. Therefore, the request was not medically necessary.

#### **Cervical Traction System for six weeks: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Online, Traction (Mechanical)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 3 Initial Approaches to Treatment Page(s): page 49: table 3-1 and page 181: table 8-8.

**Decision rationale:** As noted in the MTUS Guidelines in ACOEM Chapter 8, Table 8-8, page 181 and Chapter 3, Table 3-1, page 49, traction, the modality at issue, is deemed "not recommended." Here, the attending provider did not furnish any compelling applicant-specific rationale or medical evidence, which would offset the unfavorable ACOEM position on the article at issue. Therefore, the request was not medically necessary.

#### **Six Chiropractic Visits: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58-60.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 56-60.

**Decision rationale:** While pages 59 and 60 of the MTUS Chronic Pain Medical Treatment Guidelines support up to 24 sessions of chiropractic manipulative therapy in applicants who demonstrate a favorable response to earlier treatment by achieving and/or maintaining successful return to work status, in this case, however, the applicant was/is off of work, on total temporary disability. Earlier manipulative therapy, thus, has proven unsuccessful here. Therefore, the request was not medically necessary.

**Cold/Heat Therapy Unit for six weeks:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints Page(s): 174: table 8-5 and page 201: table 9-3. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Third Edition, Cervical and Thoracic Spine Chapter, Cryotherapy

**Decision rationale:** As noted in the MTUS Guidelines in ACOEM Chapter 8, Table 8-5, page 174 and the MTUS Guidelines in ACOEM Chapter 9, Table 9-3, page 204, at home local applications of heat and cold are recommended as methods of symptom control for applicants with neck, upper back, and/or shoulder pain complaints, as are/were present here. By implication, ACOEM does not support more elaborate devices for delivering cryotherapy. The Third Edition ACOEM Guidelines Chronic Pain Chapter takes a permanent position against usage of such high-tech devices for delivering cryotherapy, explicitly noting that such devices are deemed "not recommended." The attending provider did not furnish any compelling applicant-specific rationale, which would offset the unfavorable ACOEM positions on articles at issue. Therefore, the request was not medically necessary.

**Orthopedic Examination:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Occupational Medicine Practice Guidelines, 2nd Edition, 2004, Chapter 7, page 127

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 9 Shoulder Complaints Page(s): 180; 210.

**Decision rationale:** The applicant's primary pain generators are the cervical spine and shoulder. As noted in the MTUS Guideline in ACOEM Chapter 8, page 180, applicants with both findings of neck or upper back pain alone, without findings of associated significant nerve root compromise, rarely benefit from either surgical consultation or surgery. Here, there is no mention of the applicant considering or contemplating any kind of surgical intervention involving the cervical spine. There was no mention of the applicant having anything beyond nonspecific neck and upper back pain on or around the date in question, October 31, 2014. Similarly, the MTUS Guideline in ACOEM Chapter 9, page 210 also notes that applicants who have no clear indication for surgery involving the shoulder may benefit from referral to a

physical medicine practitioner (as opposed to referral to a surgeon). The request, thus, as written, is at odds with ACOEM principles and parameters. Therefore, the request was not medically necessary.

**Six Physical Therapy Visits:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Functional Restoration Approach to Chronic Pain Management, Physical Medicine Page(s): 8; 99.

**Decision rationale:** While page 99 of the MTUS Chronic Pain Medical Treatment Guidelines does support a general course of 9 to 10 sessions of treatment for myalgias and myositis of various body parts, the diagnosis reportedly present here, this recommendation is, however, qualified by commentary made on page 8 of the MTUS Chronic Pain Medical Treatment Guidelines to the effect that demonstration of functional improvement is necessary at various milestones in the treatment program in order to justify continued treatment. Here, the applicant was/is off of work, on total temporary disability, suggesting a lack of functional improvement as defined in MTUS 9792.20(f). Therefore, the request was not medically necessary.

**Weekly Toxicology Testing (#6):** 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 Drug Testing Page(s): 43. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Urine Drug Testing

**Decision rationale:** While page 43 of the MTUS Chronic Pain Medical Treatment Guidelines does support intermittent drug testing in the chronic pain population, the MTUS does not establish specific parameters for or identify a frequency with which to perform drug testing. The Official Disability Guidelines Chronic Pain Chapter, Urine Drug Testing Topic, however, notes that an attending provider should clearly state which drug testing and/or drug panels he intends to test for, attach an applicant's complete medication list to request for authorization of testing, should attempt to conform to the best practices of the United States Department of Transportation when performing drug testing, should eschew confirmatory and/or quantitative testing outside the emergency department drug overdose context, and should attempt to categorize applicants into higher or lower risk categories for which more or less frequent testing would be indicated. Here, however, the attending provider did not state when the applicant was last tested. The attending provider did not clearly state what drug testings and/or drug panels he intends to test for. The attending provider did not indicate his willingness to forego confirmatory and/or quantitative testing. The attending provider did not classify the applicant into higher or

lower risk categories for which more or less frequent testing would be indicated. Since several ODG criteria for pursuit of drug testing were not met, the request was not medically necessary.

**Home Exercise Rehab Kit:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Online, Home Exercise Kits

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management, Chapter 12 Low Back Complaints Page(s): 83, 309: table 12-8, Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98.

**Decision rationale:** The nature of the request is imprecise. However, the MTUS Guideline in ACOEM Chapter 12, Table 12-8, page 309 notes that back specific exercise machines, an article essentially analogous to the request at issue, are deemed "not recommended." Similarly, the MTUS Guideline in ACOEM Chapter 5, page 83 notes that, to achieve functional recovery, applicants must assume certain responsibilities, one of which includes adhering to and maintaining exercise regimens. Finally, page 98 of the MTUS Chronic Pain Medical Treatment Guidelines notes that applicants are expected to continue active therapies at home as an extension of the treatment process. Thus, the ACOEM Chapter 5, page 83 and page 98 of the MTUS Chronic Pain Medical Treatment Guidelines seemingly espouse the position that home exercise kits in the like are articles of applicant responsibility as opposed to articles of payor responsibility. Here, the attending provider has not, it is further noted, clearly outlined why the applicant cannot perform home exercise of his own accord, as suggested by both ACOEM and the MTUS Chronic Pain Medical Treatment Guidelines. Therefore, the request was not medically necessary.

**Naproxen 550mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 66 & 73.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Inflammatory Medications, Functional Restoration Approach to Chronic Pain Management Page(s).

**Decision rationale:** The nature of the request is imprecise. However, the MTUS Guideline in ACOEM Chapter 12, Table 12-8, page 309 notes that back specific exercise machines, an article essentially analogous to the request at issue, are deemed "not recommended." Similarly, the MTUS Guideline in ACOEM Chapter 5, page 83 notes that, to achieve functional recovery, applicants must assume certain responsibilities, one of which includes adhering to and maintaining exercise regimens. Finally, page 98 of the MTUS Chronic Pain Medical Treatment Guidelines notes that applicants are expected to continue active therapies at home as an extension of the treatment process. Thus, the ACOEM Chapter 5, page 83 and page 98 of the MTUS Chronic Pain Medical Treatment Guidelines seemingly espouse the position that home

exercise kits in the like are articles of applicant responsibility as opposed to articles of payor responsibility. Here, the attending provider has not, it is further noted, clearly outlined why the applicant cannot perform home exercise of his own accord, as suggested by both ACOEM and the MTUS Chronic Pain Medical Treatment Guidelines. Therefore, the request was not medically necessary.

**Prilosec 20mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 69.

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

**Decision rationale:** While page 69 of the MTUS Chronic Pain Medical Treatment Guidelines does acknowledge that proton pump inhibitors such as Prilosec are indicated in the treatment of NSAID-induced dyspepsia, in this case, however, the information on file, including the October 31, 2014 progress note at issue, contained no references to issues with reflux, heartburn, and/or dyspepsia, either NSAID-induced or stand-alone. Therefore, the request was not medically necessary.

**Flexeril 10mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 41 & 64.

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

**Decision rationale:** As noted on page 41 of the MTUS Chronic Pain Medical Treatment Guidelines, the addition of cyclobenzaprine or Flexeril to other agents is not recommended. Here, the applicant was/is using a variety of other agents, including Naprosyn. Adding cyclobenzaprine or Flexeril to the mix is not recommended. It is further noted that the 60-tablet supply of cyclobenzaprine at issue represents treatment well in excess of the "short course of therapy" for which cyclobenzaprine is recommended, per page 41 of the MTUS Chronic Pain Medical Treatment Guidelines. Therefore, the request was not medically necessary.

**EMG of the Right Upper Extremity:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

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

**Decision rationale:** As noted in the MTUS Guideline in ACOEM Chapter 8, Table 8-8, page 182, EMG testing is "not recommended" for a diagnosis of nerve root involvement if findings of history, physical exam, and imaging study are consistent. Here, the applicant, per the treating provider, has had cervical MRI imaging demonstrating a herniated disc at the C5-C6 level; per January 8, 2015 progress note. This finding does account for the applicant's ongoing radicular complaints and effectively obviates the need for the EMG testing at issue. Therefore, the request was not medically necessary.

**EMG of the Left Upper Extremity:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 272: table 11-7.

**Decision rationale:** As noted in the MTUS Guideline in ACOEM Chapter 11, Table 11-7, page 272, the routine usage of NCV or EMG testing in the evaluation of applicants without symptoms is deemed "not recommended." Here, the documentation on file all points to the applicant's symptoms being confined to the right upper extremity. There was no mention of the applicant as having any neurologic or radicular symptoms about the seemingly asymptomatic left upper extremity. Therefore, the request was not medically necessary.

**NCV of the Right Upper Extremity:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178, 182: table 8-8.

**Decision rationale:** While the MTUS Guideline in ACOEM Chapter 8, page 178 does acknowledge that EMG or NCV testing can be employed to identify subtle, focal neurologic dysfunction in applicants with neck or arm symptoms which last greater than three or four weeks, this recommendation is, however, qualified by the MTUS position in ACOEM Chapter 8, Table 8-8, page 182 to the effect that electrodiagnostic testing for a diagnosis of nerve root involvement is deemed "not recommended" if findings of history, physical exam, and/or imaging study are consistent. Here, the attending provider acknowledged in a January 8, 2015 progress note that the applicant had radiographically confirmed C5-6 radiculopathy, effectively obviating the need for the nerve conduction testing at issue. Therefore, the request was not medically necessary.

**NCV of the Left Upper Extremity:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 272: table 11-7.

**Decision rationale:** As noted in the MTUS Guideline in ACOEM Chapter 11, Table 11-7, page 272, the routine usage of NCV or EMG testing in the evaluation of applicants without symptoms is deemed "not recommended." Here, all evidence on file points to the applicant being entirely asymptomatic insofar as the left upper extremity is concerned. There is no mention of the applicant as having any issues with left upper extremity neuropathic or radicular pain complaints. Therefore, the request was not medically necessary.