

Case Number:	CM15-0018313		
Date Assigned:	02/06/2015	Date of Injury:	10/01/2002
Decision Date:	04/02/2015	UR Denial Date:	01/16/2015
Priority:	Standard	Application Received:	01/30/2015

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:

This 62 year old male sustained an industrial injury on 10/1/02. He subsequently reports chronic back, bilateral lower extremity and left shoulder pain. Diagnoses include bilateral knee osteoarthritis, status post right total knee replacement, chronic cervical strain, right upper extremity radicular pain and numbness and status post left shoulder arthroscopy. Treatment to date has included surgery, a single point cane and pain medications. On 1/16/2015, Utilization Review non-certified requests for an MRI (magnetic resonance imaging) of the cervical spine and EMG (electromyography)/NCV (nerve conduction velocity) of the bilateral upper extremities were denied based on ODG guidelines. The Flurbiprofen/Lidocaine Cream (20%/5%) 180gm, Norco (Hydrocodone) 7.5/325mg #60, Soma (Carisoprodol) 350mg, #60 and Flurbiprofen/Lidocaine Cream (20%/5%) 180gm were denied based on MTUS Chronic Pain Treatment guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI (magnetic resonance imaging) of the cervical spine: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS 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 chapter 'Neck and Upper Back (Acute & Chronic)' and topic 'Magnetic resonance imaging (MRI)'.

Decision rationale: This patient presents with persistent neck pain that radiates into the left shoulder, left shoulder pain, bilateral knee pain and is status post TKA from 2008. The current request is for MRI OF CERVICAL SPINE. ACOEM Guidelines, chapter 8, page 177 and 178, state: Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. ODG Guidelines, chapter 'Neck and Upper Back (Acute & Chronic)' and topic 'Magnetic resonance imaging (MRI)', have the following criteria for cervical MRI: (1) Chronic neck pain (= after 3 months conservative treatment), radiographs normal, neurologic signs or symptoms present (2) Neck pain with radiculopathy if severe or progressive neurologic deficit (3) Chronic neck pain, radiographs show spondylosis, neurologic signs or symptoms present (4) Chronic neck pain, radiographs show old trauma, neurologic signs or symptoms present (5) Chronic neck pain, radiographs show bone or disc margin destruction (6) Suspected cervical spine trauma, neck pain, clinical findings suggest ligamentous injury (sprain), radiographs and/or CT "normal" (7) Known cervical spine trauma: equivocal or positive plain films with neurological deficit (8) Upper back/thoracic spine trauma with neurological deficit. The utilization review denied the request stating that the physical exam does not specify a specific myotomal weakness. The treating physician requested authorization for an MRI as there is persistent pathology and decreased functionality. Progress reports 1/3/14 through 2/4/15 were reviewed and provides no discussions regarding prior MRI. Given the patient's date of injury which dates back to 2002, it is possible that this patient had some imaging done in the past. In this case, given the patient's persistent complaints of pain and objective findings which include tenderness, hypertonicity, positive Spurling's test and decreased sensation, an MRI of the cervical spine IS medically necessary.

EMG (electromyography)/NCV (nerve conduction velocity) of the bilateral upper extremities: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 178. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Electrodiagnostic testing.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 260-262. Decision based on Non-MTUS Citation Official disability guidelines Neck and upper back chapter, EMG/NCV studies.

Decision rationale: This patient presents with persistent neck pain that radiates into the left shoulder, left shoulder pain, bilateral knee pain and is status post TKA from 2008. The current request is for EMG OF THE BILATRAL UPPER EXTREMITIES. For EMG of the upper extremities, the ACOEM Guidelines page 206 states that electrodiagnostic studies may help differentiate between CTS and other conditions such as cervical radiculopathy. The ODG guidelines Online, Cervical chapter: Electromyography (EMG) state that EMG is recommended as an option in selected cases. The utilization review denied the request stating that stating that charts notes do not specify a specific differential diagnosis and it is unclear why the patient would need both EMG and NCV. The treating physician states that an EMG/NCV would be appropriate given the patient's radicular pain emanating from the neck to left shoulder. There is no prior EMG testing found in the medical records provided. The treating physician states that an EMG is being requested to rule out right brachial plexopathy or neuropathy. There is no indication the patient has had an EMG in the past; therefore, an EMG to establish the presence of radiculopathy is within medically guidelines. This request IS medically necessary.

Flurbiprofen/Lidocaine Cream (20%/5%) 180gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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

Decision rationale: This patient presents with persistent neck pain that radiates into the left shoulder, left shoulder pain, bilateral knee pain and is status post TKA from 2008. The current request is for FLURBIPROFEN/LIDOCAINE CREAM 20%/5% 180GM. 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 neck and shoulder pain. In addition, lidocaine is only allowed in a patch form and not allowed in a cream, lotion, or gel forms. This topical compound medication IS NOT medically necessary.

Norco (Hydrocodone) 7.5/325mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Short-acting opioids; On-going management.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 76-78, 88-89.

Decision rationale: This patient presents with persistent neck pain that radiates into the left shoulder, left shoulder pain, bilateral knee pain and is status post TKA from 2008. The current request is for NORCO 7.5/325 #60. For chronic opiate use, the MTUS guidelines pages 88 and 89 states: Pain should be assessed at each visit and function should be measured at 6-month intervals using a numerical scale or validated instrument. The MTUS page 78 also requires documentation of the 4 A's, which includes analgesia, ADLs, adverse side effects, and aberrant behavior. MTUS also requires pain assessment or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work, and duration of pain relief. This patient has been utilizing Norco since at least 1/3/14. Progress reports dating from 1/3/14 through 12/16/14 provide no specific discussion regarding medication efficacy. In this case, recommendation for further use cannot be supported as the treating physician has not provided any specific functional improvement, changes in ADL's or change in work status to document significant functional improvement with utilizing long term opiate. There are no before and after pain scales provided to denote a decrease in pain with utilizing long-term opioid. A urine drug screen was administered on 12/19/14, but there are no discussions regarding aberrant behaviors or adverse side effects as required by MTUS for opiate management. The treating physician has failed to provide the minimum requirements as required by MTUS for opiate management. This request IS NOT medically necessary and recommendation is for slow weaning per MTUS.

Soma (Carisoprodol) 350mg, #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Carisoprodol (Soma) Page(s): 29. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Carisoprodol (Soma).

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

Decision rationale: This patient presents with persistent neck pain that radiates into the left shoulder, left shoulder pain, bilateral knee pain and is status post TKA from 2008. The current request is for NORCO 7.5/325 #60. For chronic opiate use, the MTUS guidelines pages 88 and 89 states: Pain should be assessed at each visit and function should be measured at 6-month intervals using a numerical scale or validated instrument. The MTUS page 78 also requires documentation of the 4 A's, which includes analgesia, ADLs, adverse side effects, and aberrant behavior. MTUS also requires pain assessment or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work, and duration of pain relief. This patient has been utilizing Norco since at least 1/3/14. Progress reports dating from 1/3/14 through 12/16/14 provide no specific discussion regarding medication efficacy. In this case, recommendation for further use cannot be supported as the treating physician has not provided any specific functional improvement, changes in ADL's or change in work status to document significant functional improvement with utilizing long term opiate. There are no before and after pain scales provided to denote a decrease in pain with utilizing long-term opioid. A urine drug screen was administered on 12/19/14, but there are no discussions regarding aberrant behaviors or adverse side effects as required by MTUS for opiate

management. The treating physician has failed to provide the minimum requirements as required by MTUS for opiate management. This request IS NOT medically necessary and recommendation is for slow weaning per MTUS.