

Case Number:	CM15-0136727		
Date Assigned:	07/24/2015	Date of Injury:	03/25/2014
Decision Date:	09/15/2015	UR Denial Date:	06/26/2015
Priority:	Standard	Application Received:	07/14/2015

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: New York
 Certification(s)/Specialty: Pediatrics, Internal 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 injured worker is a 47 year old female who sustained an industrial injury on 03/25/2014. The injured worker reported immediate pain in her neck, right ring finger, right little finger, upper back, lower back and right foot as a result of a motor vehicle accident. Treatment to date has included medications and physical therapy. According to an electrodiagnostic consultation and report dated 04/22/2014 nerve conduction studies were abnormal demonstrating bilateral mild compression of the median nerve at the carpal tunnel and right mild compression of the ulnar nerve at or near the medial epicondyle by electrodiagnostic criteria. Electromyography demonstrated no evidence of active cervical radiculopathy in the bilateral upper extremities. According to the most recent progress report submitted for review and dated 04/28/2015, subjective complaints included persistent neck pain that was rated 5 on a scale of 1-10 and was frequent. Lower back pain was rated 6 and was frequent. Right ankle and foot pain was rated 3 and was frequent and the same. Pain was made better with chiropractic treatment, rest and medications. Motrin helped bring pain from 6 to 3 which allowed her to continue working on full duties. She had completed 4 out of 12 chiropractic sessions with increased range of motion and decreased pain allowing her to continue working. These chiropractic progress reports were not submitted for review. Examination of the cervical spine demonstrated slight decreased range of motion in all planes. There was tenderness over the midline and paraspinals. There was decreased strength and sensation at 4/5 at C8 on the right only. Examination of the lumbar spine revealed slight decreased range of motion in all planes. There was tenderness over the midline and bilateral paraspinals. There was positive sitting straight leg raise on the right at 60 degrees.

Deep tendon reflexes were 2+ bilaterally at the patellar and Achilles tendon. Examination of the right ankle revealed slight decreased range of motion. There was weakness at 4+/5 with plantar and dorsiflexion. There was tenderness over the Achilles tendon insertion as well as over the plantar fascia and heel. Diagnoses included acute cervical strain, cervical disc bulge of 2 millimeters at C6-7, acute lumbar strain, right hand numbness, right lower extremity radicular pain, right L5 radiculopathy, bilateral mild carpal tunnel syndrome and right Achilles tendon insertional tendinitis and plantar fasciitis. Kera-Tek analgesic gel was requested in attempt to allow her to keep functioning at her job unrestricted and to reduce the amount of Motion she was taking as it was causing slight gastrointestinal upset. A prescription for Motrin was also given. She was to continue with authorized chiropractic treatment to the cervical and lumbar spine. According to a previous progress report dated 03/03/2015, the provider noted that the injured worker had completed 10 out of 12 chiropractic treatments. The provider requested authorization for 8 more sessions of chiropractic care. On 06/24/2015, the provider requested authorization for a spine surgeon consult, EMG/NCV (electromyography/nerve conduction velocity studies) of the bilateral upper extremities, Flurbiprofen/Baclofen/Lidocaine cream (20%/5%/4%) 180 grams apply a thin layer 2-3 times per day or as directed, chiropractic manipulation to the cervical and lumbar spine 2 times a week for 6 weeks and Motrin 800 mg. Currently under review is the request for EMG/NCV study of the bilateral upper extremities, one prescription for Flurbiprofen/Baclofen/Lidocaine cream, and twelve (12) chiropractic treatments for the cervical and lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

EMG/NCV study of the bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back (Acute & Chronic) EMG (electromyography); NCS (nerve conduction studies).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints.

Decision rationale: Per ODG guidelines EMG is recommended (needle, not surface) as an option in selected cases While cervical electrodiagnostic studies are not necessary to demonstrate a cervical radiculopathy, they have been suggested to confirm a brachial plexus abnormality or some problem other than a cervical radiculopathy, but these studies can result in unnecessary over treatment. Due to the concern for false positive EMG given the lack of neurologic findings, the EMG is not medically necessary and appropriate.

One prescription for Flurbiprofen/Baclofen/Lidocaine cream: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

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

Decision rationale: According to the 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, for example, NSAIDs (nonsteroidal anti-inflammatory drugs), opioids, capsaicin, local anesthetics or antidepressants. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. MTUS guidelines do not recommend Baclofen and states there is no evidence for use of any other muscle relaxant as a topical product. Flurbiprofen is a topical non-steroidal anti-inflammatory drug. Per MTUS Guidelines, topical non-steroidal anti-inflammatory drugs (NSAIDs) are used for the treatment of osteoarthritis and tendonitis, in particular, knee and elbow joints that are amenable to topical treatment. There is little evidence that supports topical NSAIDs as a treatment option for spine and shoulder conditions. The duration of effect is for a short-term use (4-12 weeks) with reported diminished effectiveness over time. Topical NSAIDs are not recommended for neuropathic pain as there is no evidence to support use. FDA approved agents include Voltaren Gel 1% which is indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee and wrist). It has not been evaluated for treatment of spine, hip or shoulder. The only FDA approved topical NSAIDs are Diclofenac formulations. All other topical NSAIDs are not FDA approved. Guidelines recommend topical Lidocaine only in the form of the Lidoderm patch for localized peripheral pain. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. In this case, the requested treatment contains at least one drug or (drug class) that is not recommended. Guidelines do not recommend Flurbiprofen or Baclofen. The requested treatment contains Lidocaine in the unapproved form. In addition, there was no discussion of trial and failure of antidepressants and anticonvulsants. The treating physician's request did not include site of application. Medical necessity for the requested treatment is not established. The requested treatment is not medically necessary.

Twelve (12) chiropractic treatments for the cervical and lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 12 Low Back Complaints Page(s): 181, 365, Chronic Pain Treatment Guidelines Manual therapy & manipulation, MTUS definitions Page(s): 58-60, 1-2.

Decision rationale: CA MTUS guidelines state manual therapy & manipulation is recommended for chronic pain if caused by musculoskeletal conditions. Manual therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of manual medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range of

motion but not beyond the anatomic range of motion. Time to produce effect is 4-6 treatments. Frequency should occur 1 to 2 times per week the first 2 weeks as indicated by the severity of the condition. Treatment may continue at 1 treatment per week for the next 6 weeks. Maximum duration is 8 weeks. At week 8, patients should be re-evaluated. Treatment beyond 4-6 visits should be documented with objective improvement in function. Per MTUS "Functional Improvement" means either a clinically significant improvement in activities of daily living or a reduction in work restrictions as measured during the history and physical exam, performed and documented as part of the evaluation and management visit billed under the Official Medical Fee Schedule (CMFS) pursuant to Sections 9789.10.9789.111; and a reduction in the dependency on continued medical treatment. MTUS states that physical manipulation of the neck and upper back is an optional treatment early in care only. There is insufficient evidence to support radiculopathy. MTUS states that manipulation for the low back for longer than 4 weeks is not recommended. In this case, it is unclear exactly how many chiropractic treatments have been completed to date. On 03/03/2015, the provider stated that 10 out of 12 sessions had been completed. Approximately 2 months later, he stated that 4 out of 12 sessions had been completed. There is a lack of functional improvement with the treatment already provided. The treating physician did not provide sufficient evidence of improvement in the work status, activities of daily living, and dependency on continued medical care. MTUS does not support continuing chiropractic care without more specific evidence of functional improvement. Documentation indicates that this is a chronic condition being treated. The amount of treatment already received and the requested treatment exceeds recommended guidelines. Medical necessity for the requested treatment is not established. The requested treatment is not medically necessary.