

Case Number:	CM15-0182660		
Date Assigned:	09/28/2015	Date of Injury:	05/13/2015
Decision Date:	11/30/2015	UR Denial Date:	09/02/2015
Priority:	Standard	Application Received:	09/16/2015

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: 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 52 year old male, who sustained an industrial injury on May 13, 2015, incurring neck, shoulder, elbow and right upper extremity injuries. He was diagnosed with a cervical sprain, right shoulder sprain, right elbow strain and a right hand and wrist sprain. Treatment included pain medications, muscle relaxants, neuropathic medications, topical analgesic creams, and physical therapy twice a week for four weeks, and activity restrictions. He was placed on temporary total disability. Currently, the injured worker complained of increased pain, aching, burning, numbness and tingling aggravated with bending, lifting, and prolonged sitting, standing and walking. He rated his pain 8 out of 10 on a pain scale from 0 to 10. The treatment plan that was requested for authorization on September 16, 2015, included prescriptions for Flurbiprofen-Cyclobenzaprine compound cream; and Gabapentin-Dextromethorphan-Amitriptyline compound cream; Functional improvement measurement for the right shoulder, right elbow, right wrist, right hand and neck; Magnetic Resonance Imaging for the right shoulder, Magnetic Resonance Imaging of the right elbow, Magnetic Resonance Imaging for the right wrist, Magnetic Resonance Imaging of the neck; Urine Drug Screen; Autonomic nervous test and a Hot and Cold therapy unit. On September 2, 2015, the requested prescriptions, diagnostic imaging, testing and durable medical equipment was non-certified by utilization review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Flurbiprofen 25%/Cyclobenzaprine 2%/ compound cream 180gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

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, 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. In this case there is no documentation provided necessitating the requested treatment: Flurbiprofen 25%/Cyclobenzaprine 2%/ compound cream 180gm. One of the ingredients in this compound is Flurbiprofen. It is used as a topical NSAID. It has been shown in a meta-analysis to be superior to placebo during the first two weeks of treatment for osteoarthritis but either, not afterward, or with diminishing effect over another two-week period. There are no clinical studies to support the safety or effectiveness of Flurbiprofen in a topical delivery system (excluding ophthalmic). Cyclobenzaprine (brand names: Amrix, Flexeril and Fexmid; generic form: Tabradol) is a centrally acting skeletal muscle relaxant and is not recommended for topical application. Medical necessity for the requested topical compound medication has not been established. The requested treatment: Flurbiprofen 25%/Cyclobenzaprine 2%/ compound cream 180gm is not medically necessary.

Gabapentin 15%/Dextromethorphan/ Amitriptyline 4% 180 gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: According to the California MTUS Guidelines (2009), 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, opioids, capsaicin, muscle relaxants, local anesthetics or antidepressants. Guidelines indicate that any compounded product that contains at least one non-recommended drug (or drug class) is not recommended for use. Gabapentin is not recommended. There is no peer-reviewed literature to support its use. There is no documentation in the submitted Medical Records that the

injured worker has failed a trial of antidepressants and anticonvulsants. In this injured worker, the medical necessity for the requested topical cream has not been established. Therefore, as per guidelines stated above, the requested topical cream is not medically necessary.

Functional Improvement Measurement for the right shoulder, right elbow, right wrist, right hand and neck: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Chapter 7: Independent Medical Examinations and Consultations, pages 127 Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Functional improvement measures.

Decision rationale: Functional improvement measurement is recommended for demonstrating maintenance and improvement in function. No specific guidelines are offered by NIOSH website (www.cdc.gov/niosh). There is no need for any special techniques. The importance of an assessment is to have a measure that can be used repeatedly over the course of treatment to demonstrate improvement of function, or maintenance of function that would otherwise deteriorate. It should include the following categories: Work Functions and/or Activities of Daily Living, Self-Report of Disability (e.g., walking, driving, keyboard or lifting tolerance, Oswestry, pain scales, etc.): Objective measures of the patient's functional performance in the clinic (e.g., able to lift 10 lbs. floor to waist x 5 repetitions) are preferred, but this may include self-report of functional tolerance and can document the patient self-assessment of functional status through the use of questionnaires, pain scales, etc. (Oswestry, DASH, VAS, etc.) Physical Impairments (e.g., joint ROM, muscle flexibility, strength, or endurance deficits): Include objective measures of clinical exam findings. ROM should be documented in degrees. Approach to Self-Care and Education Reduced Reliance on Other Treatments, Modalities, or Medications: This includes the provider's assessment of the patient compliance with a home program and motivation. The provider should also indicate a progression of care with increased active interventions (vs. passive interventions) and reduction in frequency of treatment over course of care. For chronic pain, also consider return to normal quality of life, e.g., go to work/volunteer each day; normal daily activities each day; have a social life outside of work; take an active part in family life. The functional improvement testing can be done in a clinical setting on routine office visits and there is no need for specialized testing, therefore, requested treatment is not medically necessary and appropriate.

MRI without contrast for the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Magnetic resonance imaging (MRI).

Decision rationale: As per ODG -criteria for MRI (magnetic resonance imaging): Acute shoulder trauma, suspect rotator cuff tear/impingement; over age 40; normal plain radiographs; Subacute shoulder pain, suspect instability/labral tear; Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. Review of submitted Records indicates that injured worker is diagnosed with a cervical sprain, right shoulder sprain, right elbow strain and a right hand and wrist sprain. As per progress notes in the Medical Records, the injured worker does not appear to have significant changes in symptoms and signs. The records are not clear about neurological findings, and there are no red flags. Without such evidence, and based on guidelines cited, the request for MRI Right Shoulder is not medically necessary and appropriate.

MRI of the right elbow: 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: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Elbow Chapter, Magnetic resonance imaging (MRI).

Decision rationale: Magnetic resonance imaging may provide important diagnostic information for evaluating the adult elbow in many different conditions, including: collateral ligament injury, epicondylitis, injury to the biceps and triceps tendons, abnormality of the ulnar, radial, or median nerve, and for masses about the elbow joint. There is a lack of studies showing the sensitivity and specificity of MR in many of these entities; most of the studies demonstrate MR findings in patients either known or highly likely to have a specific condition. Magnetic resonance may be useful for confirmation of the diagnosis in refractory cases and to exclude associated tendon and ligament tear. Review of submitted Records indicates that injured worker is diagnosed with a cervical sprain, right shoulder sprain, right elbow strain and a right hand and wrist sprain. As per progress notes in the Medical Records, the injured worker does not appear to have significant changes in symptoms and signs. The records are not clear about neurological findings, and there are no red flags. There is no documentation of failed conservative measures and no reports of prior imaging, if any can be located within the submitted medical records. Without such evidence, and based on guidelines cited, the request for MRI Right Elbow is not medically necessary and appropriate.

MRI without contrast for the right wrist: Upheld

Claims Administrator guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Forearm, Wrist, & Hand Chapter, MRI's (magnetic resonance imaging).

Decision rationale: California MTUS states imaging studies to clarify the diagnosis may be warranted if the medical history and physical examination suggest specific disorders. Official Disability Guidelines (ODG) state that indications for MRI of the wrist are acute hand or wrist trauma, suspect acute scaphoid fracture, radiographs normal, next procedure if immediate confirmation or exclusion of fracture is required, acute hand or wrist trauma, suspect gamekeeper injury (thumb MCP ulnar collateral ligament injury), chronic wrist pain, plain films normal, suspect soft tissue tumor, chronic wrist pain, plain film normal or equivocal, suspect Kienbock's disease. Review of submitted Records indicates that injured worker is diagnosed with a cervical sprain, right shoulder sprain, right elbow strain and a right hand and wrist sprain. As per progress notes in the Medical Records, the injured worker does not appear to have significant changes in symptoms and signs. The records are not clear about abnormal neurological findings. There is no evidence of suspected fracture, no recent injury and there are no red flags. There is no documentation of failed conservative measures and no reports of prior imaging, if any can be located within the submitted medical records. Based on submitted information, the requested treatment MRI of the right wrist without contrast cannot be determined as medically necessary and appropriate.

MRI without contrast for the neck: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck Chapter, Magnetic resonance imaging (MRI).

Decision rationale: MTUS/ACOEM state many patients with strong clinical findings of nerve root dysfunction due to disk herniation recover activity tolerance within one month; there is no evidence that delaying surgery for this period worsens outcomes in patients without progressive neurologic findings. Spontaneous improvement in MRI documented cervical disk pathology has been demonstrated with a high rate of resolution. As per ODG-criteria for MRI (magnetic resonance imaging): Chronic neck pain (= after 3 months conservative treatment), radiographs normal, neurologic signs or symptoms present; Neck pain with radiculopathy if severe or progressive neurologic deficit; Chronic neck pain, radiographs show spondylosis, neurologic signs or symptoms present; Chronic neck pain, radiographs show old trauma, neurologic signs or symptoms present; Chronic neck pain, radiographs show bone or disc margin destruction; Suspected cervical spine trauma, neck pain, clinical findings suggest ligamentous injury (sprain), radiographs and/or CT "normal" Known cervical spine trauma: equivocal or positive plain films with neurological deficit. Upper back/thoracic spine trauma with neurological deficit Review of submitted Records indicates that injured worker is diagnosed with a cervical sprain, right shoulder sprain, right elbow strain and a right hand and wrist sprain. As per progress notes in the Medical Records, the injured worker does not appear to have significant changes in symptoms and signs. The records are not clear about neurological findings, and there are no red flags. There is no documentation of failed conservative measures and no reports of prior imaging, if any can be located within the submitted medical records. Without such evidence and based on guidelines cited, the request for MRI neck is not medically necessary and appropriate.

Urine drug screen: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Drug testing.

Decision rationale: Per the CA MTUS, drug testing is recommended as an option, using a urine drug screen to assess for the use or the presence of illegal drugs. The CA MTUS recommends in on-going opioid management, drug screening or inpatient treatment for those patients with issues of abuse, addiction, or poor pain control, along with documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion). In this case, there is no discussion of abuse, addiction, or poor pain control, along with documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion). There is no clear rationale in the medical records that meets the recommended guidelines for this request. Therefore, the request for Urine Drug Screen is not medically necessary.

Autonomic nervous test: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Aetna.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.phoenixneurology.com/testing/autonomic.php>.

Decision rationale: CA MTUS and ODG do not address this, therefore alternate guidelines were reviewed. Autonomic Testing is done to see if a disease is affecting the autonomic nervous system, several tests are done to monitor blood pressure, blood flow, heart rate, and sweating. By measuring these functions, it is possible to discover whether or not the autonomic nervous system is functioning normally. Quantitative Sudomotor Autonomic Reflex Test (QSART) measures sweating and skin temperature. QSART is used to diagnose: Painful, small fiber neuropathy when nerve conduction test results are normal. Disturbances of the autonomic nervous system, which controls the sweat glands, heart, digestive system, other organs, and blood pressure. Complex pain disorders Autonomic testing is considered experimental and investigational. The provider's notes are not clear about any significant changes in the symptoms or clinical findings in this injured worker and review of submitted medical records do not provide clear rationale to support the appropriateness of this test in this injured worker. The Requested Treatment: Autonomic nervous test is not medically necessary.

Hot/Cold therapy unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Aetna.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg Chapter, Cold/heat packs.

Decision rationale: ODG recommends Ice massage compared to control had a statistically beneficial effect on ROM, function and knee strength. Cold packs decreased swelling. Hot packs had no beneficial effect on edema compared with placebo or cold application. Ice packs did not affect pain significantly compared to control in patients with knee osteoarthritis ODG states Continuous-flow cryotherapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage. This meta-analysis showed that cryotherapy has a statistically significant benefit in postoperative pain control, while no improvement in postoperative range of motion or drainage was found. As the cryotherapy apparatus is fairly inexpensive, easy to use, has a high level of patient satisfaction, and is rarely associated with adverse events, we believe that cryotherapy is justified in the postoperative management of surgery. Although the use of equipment is appropriate post-operatively, the medical records neither indicate that this injured worker had any recent surgery nor, is scheduled to have one. As such, there is no indication for use of cold unit at this time. For heat therapy special equipment is not needed. ODG also state mechanical circulating units with pumps have not been proven to be more effective than passive hot and cold therapy. The requested treatment Cold/Heat therapy unit is not medically necessary and appropriate.