

Case Number:	CM15-0183006		
Date Assigned:	09/30/2015	Date of Injury:	12/26/2011
Decision Date:	12/09/2015	UR Denial Date:	08/19/2015
Priority:	Standard	Application Received:	09/17/2015

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: Tennessee, Florida, Ohio
 Certification(s)/Specialty: Surgery, Surgical Critical Care

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 12-26-2011. Treatment to date has included physical therapy, chiropractic treatment and medications. According to an initial comprehensive pain management examination report dated 07-13-2015, the injured worker reported low back pain that was constant aching, sharp, shooting and burning and was associated with radiating pain, numbness and weakness to both lower extremities and both heels. Mid back pain was described as aching, sharp, shooting and burning. Neck pain was constant aching with associated headaches and radiating pain, numbness and weakness to both upper extremities and both hands and fingers. Right shoulder pain was described as aching and shooting. Arms and forearms pain was described as constant aching, sharp and shooting pain and was associated with weakness. She also reported loss of sleep due to pain, anxiety and depression. Diagnoses included cervical myositis myalgia, cervical radiculopathy, cervical spine sprain strain, cephalgia, thoracic spine sprain strain, lumbar myositis myalgia, lumbar radiculopathy, lumbar spine sprain strain, shoulder internal derangement, shoulder rotator cuff syndrome, bilateral limb arms forearms pain, insomnia, anxiety and depression. The injured worker displayed positive objective findings in the cervical, thoracic and lumbar spine with bilateral paraspinal tenderness, myospasm and reduced range of motion. There were trigger points noted in the paracervical and paralumbar musculatures. There was decreased dermatomal sensation in the upper and lower extremities. There was decreased motor strength in the upper and lower extremities. The cervical compression, cervical distraction and straight leg raise tests were bilaterally positive. There was tenderness and decreased range of motion in the right

shoulder as well as bilateral arms and forearms. The treatment plan included a urine drug screen without Suboxone, continuation of Ibuprofen, topical compound creams, chiropractic treatment, shockwave therapy, Solace Multi-Stim unit, EMG (Electromyography) and NCV (Nerve Conduction Velocity) Study of the bilateral upper extremities, cervical paraspinal muscles, bilateral lower extremities and lumbosacral paraspinal muscles, MRI of the cervical, thoracic and lumbar spine and right shoulder, lumbar brace and respiratory cardiovascular test A.N.S. and Sudoscan. On 08-19-2015, Utilization Review non-certified the request for retrospective urine drug screen-without Suboxone performed 07-13-2015, Amitriptyline/Gabapentin/Bupivacaine/Hyaluronic Acid cream 240 grams, Flurbiprofen/Baclofen/Dexamethasone/Menthol/Camphor/Capsaicin/Hyaluronic Acid cream 240 grams, shockwave therapy for upper extremities and lower extremities quantity 3, Solace Multi-Stim unit, EMG of bilateral upper extremities and cervical paraspinal muscles, NCV of bilateral upper extremities and cervical paraspinal muscles, EMG of bilateral lower extremities and lumbosacral paraspinal muscles, NCV of bilateral lower extremities and lumbosacral paraspinal muscles, MRI of the cervical, thoracic and lumbar spine and right shoulder, lumbar brace and respiratory cardiovascular test A.N.S. and Sudoscan and modified the request for chiropractic treatment for cervical, lumbar and both shoulders quantity 18 and authorized the request for Ibuprofen.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retrospective Urine drug screen-without Suboxone performed 07/13/2015: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines.

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

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of a urine drug screen for this patient. The clinical records submitted do not support the fact that this patient has been documented to have a positive drug screen for illicit or non-prescribed substances. The MTUS guidelines recommend frequent and random urine drug screens where aberrant behavior is suspected. This patient has not been documented to have suspicion of aberrant behavior. Her pain is documented as well controlled and past drug screens are consistent with currently prescribed medications. Therefore, based on the submitted medical documentation, the request is not medically necessary.

Amitriptyline/Gabapentin/Bupivacaine/Hyaluronic Acid cream 240gm: 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 based on Non-MTUS Citation Official Disability Guidelines (ODG) Topical Analgesics.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this medication for this patient. Per the California MTUS Chronic Pain guidelines, topical analgesics are not recommended as an option for chronic pain control and are largely experimental in use with few randomized control trials to determine efficacy or safety. Any compounded product that contains at least one drug or drug class that is not recommended is not recommended as a whole. The requested cream is a combination of multiple medications. Compounded medications are not FDA approved or recommended by ODG guidelines due to concerns of purity and efficacy. Hence, the request for this compounded medication is not appropriate or indicated by MTUS and ODG guidelines. Therefore, based on the submitted medical documentation, the request is not medically necessary.

Flurbiprofen/Baclofen/Dexamethasone/Menthol/Camphor/Capsaicin/Hyaluronic Acid cream 240gm: 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 based on Non-MTUS Citation Official Disability Guidelines (ODG) Topical Analgesics.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this medication for this patient. Per the California MTUS Chronic Pain guidelines, topical analgesics are not recommended as an option for chronic pain control and are largely experimental in use with few randomized control trials to determine efficacy or safety. Any compounded product that contains at least one drug or drug class that is not recommended is not recommended as a whole. The requested cream is a combination of multiple medications. Compounded medications are not FDA approved or recommended by ODG guidelines due to concerns of purity and efficacy. Hence, the request for this compounded medication is not appropriate or indicated by MTUS and ODG guidelines. Therefore, based on the submitted medical documentation, the request is not medically necessary.

Chiropractic treatment for cervical, lumbar and both shoulders (18-sessions): 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): Manual therapy & manipulation.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this intervention for this patient. The California MTUS Guidelines state that Chiropractic manipulation is recommended for the treatment of chronic pain that has acute flares or requires therapeutic care. However, it is not recommended for elective or for maintenance therapy. The medical records support that this patient has chronic back pain, which

has been stable with no recent flare-ups or acute interventions. The patient's pain appears to be at a steady state for which he has been receiving medical therapy on a routine basis. MTUS does not support the need for manipulation as maintenance therapy. Therefore, based on the submitted medical documentation, the request is not medically necessary.

Shockwave therapy for upper extremities and lower extremities (3-sessions): Upheld

Claims Administrator guideline: Decision based on MTUS Elbow Complaints 2007. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee and Leg (Acute and Chronic).

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Initial Care, Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Extracorporeal Shock Wave Therapy.

Decision rationale: The MTUS Chronic Pain Guidelines do not address the topic of shockwave therapy. ACOEM Guidelines state, "There is no high-grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction, heat/cold applications, massage, diathermy, cutaneous laser treatment, ultrasound, transcutaneous electrical neurostimulation (TENS) units, and biofeedback. These palliative tools may be used on a trial basis but should be monitored closely." The Official Disability Guidelines note extracorporeal shock wave therapy is recommended for patients whose pain from calcifying tendinitis of the shoulder has remained despite six months of standard treatment. Within the provided documentation, the Guidelines recommend the use of shockwave treatment for the shoulder; however, there are no indications for use in the lower extremities. Within the provided documentation, the requesting physician did not include an adequate and complete assessment of the patient's current objective functional condition in order to demonstrate functional deficits needing to be addressed with the treatments. Additionally, the requesting physician's rationale for the request was unclear. Therefore, based on the submitted medical documentation, the request is not medically necessary.

Solace Multi-Stim unit: 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): Transcutaneous electrotherapy.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of a TENS unit for this patient. The California MTUS guidelines recommend the following regarding criteria for TENS unit use: 1. Chronic intractable pain (for the conditions noted above): Documentation of pain of at least three months duration. 2. There is evidence that other appropriate pain modalities have been tried (including medication) and failed a one-month trial period of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; rental would be preferred

over purchase during this trial. 3. Other ongoing pain treatment should also be documented during the trial period including medication usage. 4. A treatment plan including the specific short- and long-term goals of treatment with the TENS unit should be submitted. 5. A 2-lead unit is generally recommended; if a 4-lead unit is recommended, there must be documentation of why this is necessary. This patient's case does not meet the recommended criteria since no treatment plan (that includes short and long-term goals) was submitted. Therefore, based on the submitted medical documentation, the request is not medically necessary.

EMG of bilateral upper extremities and cervical paraspinal muscles: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain, EMG/NCS and Other Medical Treatment Guidelines American Association of Neuromuscular & Electrodiagnostic Medicine.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of EMG testing for this patient. The California MTUS guidelines and the ACOEM Guidelines do not address the topic of EMG testing. The Official Disability Guidelines (ODG) states that EMG is not recommended if radiculopathy is already clinically obvious. Additionally, the American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM) recommends EMG testing only for medical indicated conditions, not for screening. EMG is further recommended after conservative therapy measures have failed. This patient has clinically obvious, mild sensory deficits in a lumbar distribution on physical exam. Radiculitis is diagnosed in the medical documentation. Reportedly, mild sensory changes in the limbs have not been treated with conservative measures, including bracing or injection therapy. Therefore, based on the submitted medical documentation, the request is not medically necessary.

NCV of bilateral upper extremities and cervical paraspinal muscles: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain, EMG/NCS.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of bilateral upper and lower nerve conduction testing for this patient. The California MTUS guidelines and the ACOEM Guidelines do not address the topic of nerve conduction studies. The Official Disability Guidelines (ODG) states that NCV for the lower extremities and back are not recommended with EMG suggested as a more appropriate study. In the upper extremity, ODG states that Nerve Conduction Studies are recommended as an option after closed fractures of distal radius & ulna if necessary to assess nerve injury. Also recommended

for diagnosis and prognosis of traumatic nerve lesions or other nerve trauma. This patient has clinical symptoms of cervical myositis and lumbar radiculopathy. Per ODG, NCV is not indicated for the bilateral upper extremities based on this patient's known and established diagnosis. Furthermore, the patient has no documented signs of clinical fracture or traumatic nerve injury. There is also no documentation that this patient has failed conservative measures with splinting or injection therapy. Therefore, based on the submitted medical documentation, the request is not medically necessary.

EMG of bilateral lower extremities and lumbosacral paraspinal muscles: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (http://www.odg-twc.com/odgtwc/Low_Back.htm).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain, EMG/NCS and Other Medical Treatment Guidelines American Association of Neuromuscular & Electrodiagnostic Medicine.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of EMG testing for this patient. The California MTUS guidelines and the ACOEM Guidelines do not address the topic of EMG testing. The Official Disability Guidelines (ODG) states that EMG is not recommended if radiculopathy is already clinically obvious. Additionally, the American Association of Neuromuscular & Electrodiagnostic Medicine (AANEM) recommends EMG testing only for medical indicated conditions, not for screening. EMG is further recommended after conservative therapy measures have failed. This patient has clinically obvious, mild sensory deficits in a lumbar distribution on physical exam. Radiculitis is diagnosed in the medical documentation. Reportedly, mild sensory changes in the limbs have not been treated with conservative measures, including bracing or injection therapy. Therefore, based on the submitted medical documentation, the request is not medically necessary.

NCV of bilateral lower extremities and lumbosacral paraspinal muscles: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (http://www.odg-twc.com/odgtwc/Low_Back.htm).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain, EMG/NCS.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of bilateral upper and lower nerve conduction testing for this patient. The California MTUS guidelines and the ACOEM Guidelines do not address the topic of nerve conduction studies. The Official Disability Guidelines (ODG) states that NCV for the lower extremities and back are not recommended with EMG suggested as a more appropriate study. In the upper

extremity, ODG states that Nerve Conduction Studies are recommended as an option after closed fractures of distal radius & ulna if necessary to assess nerve injury. Also recommended for diagnosis and prognosis of traumatic nerve lesions or other nerve trauma. This patient has clinical symptoms of cervical myositis and lumbar radiculopathy. Per ODG, NCV is not indicated for the bilateral lower extremities based on this patient's known and established diagnosis. Furthermore, the patient has no documented signs of clinical fracture or traumatic nerve injury. Therefore, based on the submitted medical documentation, the request for is not medically necessary.

MRI of the cervical spine: 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, Surgical Considerations.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this imaging study for this patient. The California MTUS guidelines states, regarding special studies of the cervical spine, that the criteria for ordering imaging studies are the emergence of a red flag, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to an invasive procedure. Regarding this patient's case, the documentation provided does not suggest any significant change in symptoms. No new red flags are documented. No evidence of change in neurological dysfunction or tissue insult from the time of the patient's prior evaluation. Likewise, there is no documentation of a planned eminently invasive procedure. Therefore, based on the submitted medical documentation, the request is not medically necessary.

MRI of the thoracic spine: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, MRI.

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this request for this patient. The Medical Treatment Utilization Schedule (MTUS) addresses thoracic spine MRI magnetic resonance imaging. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 8 Neck and Upper Back Complaints states that reliance on imaging studies alone to evaluate the source of neck or upper back symptoms carries a significant risk of diagnostic confusion (false-positive test results). Radiography should be the initial studies when red flags for fracture, or neurologic deficit associated with acute trauma, tumor, or infection are present. MRI may be recommended to

evaluate red-flag diagnoses. Imaging is not recommended in the absence of red flags. MRI may be recommended to validate diagnosis of nerve root compromise, based on clear history and physical examination findings, in preparation for invasive procedure. This patient does not meet those criteria based on the medical records submitted. Therefore, based on the submitted medical documentation, the request is not medically necessary.

MRI of the lumbar spine: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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 (Acute & Chronic), MRI.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of a lower back (lumbar spine) MRI for this patient. The MTUS guidelines recommend that 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. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. In this patient's case, the patient's physical exam does not document any red flag symptoms (bowel/bladder incontinence, saddle anesthesia, fevers) or new neurologic deficits to warrant a lower back MRI study. The patient's complaints of pain are subjective. Therefore, based on the submitted medical documentation, the request is not medically necessary.

MRI of the right shoulder: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder (Acute and Chronic), MRI.

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Special Studies.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of a shoulder MRI for this patient. The MTUS guidelines recommend the following criteria for ordering special imaging studies in shoulder complaints: Emergence of a red flag (e.g., indications of intra-abdominal or cardiac problems presenting as shoulder problems). Physiologic evidence of tissue insult or neurovascular dysfunction (e.g., cervical root problems presenting as shoulder pain, weakness from a massive rotator cuff tear, or the presence of edema, cyanosis or Raynaud's phenomenon). Failure to progress in a strengthening program intended to avoid surgery. Clarification of the anatomy prior to an invasive procedure (e.g., a full-thickness rotator cuff tear not responding to conservative treatment). Regarding this patient's case, the patient does not have any red flag signs, including neurovascular impairment, torticollis or concerning local features such as a mass lesion with bony tenderness or swelling. Therefore, based on the submitted medical documentation, the request is not medically necessary.

Lumbar brace: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back- Lumbar & Thoracic (Acute and Chronic), Lumbar supports.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Lumbar supports.

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of this request for this patient. MTUS and ACOEM fail to address this topic. Per ODG, lumbar support braces are recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific lower back pain (very low-quality evidence, but may be a conservative option). The medical records for this patient reflect that he has chronic pain syndrome with back and shoulder pain, which have been treated with multiple modalities. The pain is not acute nor associated with an acute compression fracture. Therefore, based on the submitted medical documentation, the request is not medically necessary.

Respiratory/cardiovascular test: A.N.S. and Sudoscan : Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS ACOEM, Chapter 7 Independent Medical Examination and Consultations, page 127.

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

Decision rationale: There is not sufficient clinical information provided to justify the medical necessity of a history and physical exam for this patient. According to the ODG, Sudoscan is not generally recommended as a diagnostic test for CRP. The medical records support that this patient has chronic back pain, which has been stable with no recent flare-ups or acute interventions. The patient's pain appears to be at a steady state for which he has been receiving physical therapy chiropractic manipulation on a routine basis. Therefore, based on the submitted medical documentation, the request is not medically necessary.