

Case Number:	CM15-0194277		
Date Assigned:	10/08/2015	Date of Injury:	06/06/2014
Decision Date:	12/14/2015	UR Denial Date:	09/10/2015
Priority:	Standard	Application Received:	10/02/2015

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, California
 Certification(s)/Specialty: Emergency 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 60 year old male, who sustained an industrial injury on 06-06-2014. He has reported subsequent neck, head, back, bilateral shoulder, bilateral upper extremity and bilateral lower extremity pain and was diagnosed with head pain with dizziness, status post blunt head injury, cervical, thoracic and lumbar musculoligamentous strain and sprain with cervical and lumbar radiculitis, bilateral shoulder strain and sprain, bilateral shoulder impingement syndrome, bilateral elbow lateral epicondylitis and bilateral carpal tunnel syndrome. Electrodiagnostic studies of the upper extremities dated 09-08-2014 showed that dermatomal somatosensory evoked potentials of the C6 and C7 nerve roots were within normal limits. MRI results of the right shoulder dated 06-17-2015 revealed acromioclavicular osteoarthritis, supraspinatus tendinosis and subscapularis tendinosis. Treatment to date has included pain medication, physical therapy, acupuncture, injections, extracorporeal shockwave therapy, chiropractic therapy and massage. Documentation shows that Fluriflex, TGHOT, Motrin and Cyclobenzaprine were prescribed since at least 09-19-2014. The physician noted that topical medications were prescribed in order to minimize possible neurovascular complications and to avoid complications associated with the use of narcotic medications as well as upper gastrointestinal bleeding from the use of non-steroidal anti-inflammatory medications. The degree of pain relief and objective functional improvement with the use of medications was not documented in the most recent progress notes. In a progress note dated 07-29-2015, the injured worker reported neck pain that was rated as 3 out of 10 and was noted to have decreased from 6 out of 10 on the last visit. The injured worker's right shoulder, right elbow and right wrist were

noted to be asymptomatic, which was an improvement from 5 out of 10 pain during the last visit. Objective examination findings revealed grade 1 to 2 tenderness to palpation over the cervical paraspinal muscles which had decreased from grade 2 on the last visit and restricted range of motion. Work status was documented as temporarily totally disabled. The injured worker was noted to be close to maximal medical improvement. The physician noted that a physical performance FCE was being requested to ensure that the injured worker could safely meet the physical demands of his occupation. A request for authorization of physical performance FCE, urine toxicology, MRI of the cervical spine, EMG-NCV of the bilateral upper extremities, chiro evaluation and treat for cervical 2 times a week for 6 weeks (total of 12 visits), Flurbiflex 180 gm 2, TFHot 180 gm, Cyclobenzaprine 7.5 mg #60 and Motrin 400 mg #60 was submitted. As per the 09-10-2015 utilization review, the aforementioned requests were non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical performance FCE: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Work conditioning, work hardening. Decision based on Non-MTUS Citation Pain Chapter: ODG functional capacity eval.

Decision rationale: According to ODG guidelines, functional capacity evaluation is "recommended prior to admission to a work hardening program, with a preference for assessments tailored to a specific task or job." It is not recommended for routine use as part of occupational rehab or screening, or generic assessments in which the question is whether someone can do any type of job generally. The documentation does not support the IW's progress is approaching return to work status. The IW continues to report increasing pain despite multiple treatment approaches. There is no documentation of decreased reliance on medications. The MTUS for Chronic Pain and the Official Disability Guidelines recommend a functional capacity evaluation for Work Hardening programs, which is not the context in this case. The treating physician has not defined the components of the functional capacity evaluation. Given that there is no formal definition of a functional capacity evaluation, and that a functional capacity evaluation might refer to a vast array of tests and procedures, medical necessity for a functional capacity evaluation, cannot be determined without a specific prescription which includes a description of the intended content of the evaluation. The MTUS for Chronic Pain, in the Work Conditioning-Work Hardening section, mentions a functional capacity evaluation as a possible criterion for entry, based on specific job demands. The request for a functional capacity evaluation is not medically necessary.

Urine toxicology: 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): Opioids for chronic pain, Opioids, differentiation: dependence & addiction, Opioids, screening for risk of addiction (tests).

Decision rationale: Medical necessity for a urine drug screen is predicated on a chronic opioid therapy program conducted in accordance with the recommendations of the MTUS, or for a few other, very specific clinical reasons. There is no evidence in this case that opioids are prescribed according to the criteria outlined in the MTUS, as noted in prior UR and in this review. The treating physician has not listed any other reasons to do the urine drug screen. The collection procedure was not specified. The MTUS recommends random drug testing, not at office visits. The treating physician has not discussed the presence of any actual random testing. The details of testing have not been provided. Potential problems with drug tests include: variable quality control, forensically invalid methods of collection and testing, lack of random testing, lack of MRO involvement, unnecessary testing, and improper utilization of test results. The specific content of the test should be listed, as many drug tests do not assay the correct drugs. The urine drug screen is not medically necessary based on lack of a clear collection and testing protocol, lack of details regarding the testing content and protocol, and lack of a current opioid therapy program which is in accordance with the MTUS.

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): Physical Examination, Diagnostic Criteria, Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back: Magnetic Resonance Imaging.

Decision rationale: CA MTUS ACOEM guidelines recommends imaging studies for cases "in which surgery is considered or red-flag diagnoses are being evaluated." With respect to cervical magnetic resonance imaging studies, other indications include neck, shoulder, posterior arm pain or paresthesias or postlaminectomy syndrome. ODG guidelines recommend an MRI for the following indications only "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." The IW does not have any of these indications. In the absence of appropriate indications or physical exam finding, the request for a cervical MRI is not medically necessary.

EMG/NCV of the bilateral upper extremities: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines.

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

Decision rationale: The IW has previously had EMG/NCV testing. Results from those tests were not available for review. There are no reports from the prescribing physician which adequately present new neurologic findings leading to medical necessity for repeat electrodiagnostic testing. Non-specific pain or paresthesias are not an adequate basis for performance of EMG or NCV. Medical necessity for electrodiagnostic testing is established by a clinical presentation with a sufficient degree of neurologic signs and symptoms to warrant such tests. Non-specific, non-dermatomal extremity symptoms are not sufficient alone to justify electrodiagnostic testing. The MTUS, per the citations listed above, outlines specific indications for electrodiagnostic testing, and these indications are based on specific clinical findings. The physician should provide a diagnosis that is likely based on clinical findings, and reasons why the test is needed. The clinical evaluation is minimal and there is no specific neurological information showing the need for electrodiagnostic testing. For example, a diagnosis of radiculopathy should be supported by the signs and symptoms listed in the MTUS cited above. Based on the recent clinical information, there are no neurologic abnormalities and no specific neurologic symptoms. Based on the current clinical information, electrodiagnostic testing is not medically necessary, as the treating physician has not provided the specific indications and clinical examination outlined in the MTUS.

Chiro evaluation and treat for cervical 2 times a week for 6 weeks (total of 12 visits):
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): Physical Medicine.

Decision rationale: CA MTUS chronic pain guidelines for manual therapy and manipulation are used in support of this decision. It is assumed this request is for first time chiropractor evaluation and treatment. Documentation does not support the IW has previously undergone such treatments. According to referenced guidelines, manual therapies are recommended for musculoskeletal conditions. It is unclear from documentation, what body part the chiropractor care is intended to treat. Nonetheless, a trial of 6 visits over 2 weeks with evidence of functional improvements. The request for 12 visits exceeds this recommendation. The request for 2x6 chiropractic treatment is not medically necessary.

Flurbiflex 180gm 2: 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: Physician reports do not discuss the specific indications and medical evidence in support of the topical medications prescribed in this case. The ingredients of the requested topical agent, Flurbiflex, is not documented in the record and unknown. The specific indications of this topical analgesic for this injured worker is not documented. Per the MTUS, any compounded product that contains at least one drug that is not recommended, is not recommended. As the ingredients of this product are not know, it cannot be evaluated for adherence to the guidelines. Additionally, the request does not include dosing frequency, duration or location of application. The request is not medically necessary.

TGHot 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: No physician reports discuss the specific indications and medical evidence in support of the topical medications prescribed in this case. The ingredients appear to include tramadol-gabapentin-menthol-camphor-capsaicin. The treating physician has not discussed the ingredients of this topical agent and the specific indications for this injured worker. Per the MTUS, any compounded product that contains at least one drug that is not recommended, is not recommended. One of the included compounds in the requested medication is Gabapentin. MTUS guidelines states that gabapentin is not recommended as there is no peer-reviewed literature to support its use. Additionally, the request does not include dosing frequency or duration. The request is not medically necessary.

Cyclobenzaprine 7.5mg #60: 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): Cyclobenzaprine (Flexeril).

Decision rationale: According to CA MTUS, cyclobenzaprine is recommended as an option for short course of therapy. Effect is noted to be modest and is greatest in the first 4 days of treatment. The IW has been receiving this prescription for a minimum of 12 months according to submitted records. This greatly exceeds the recommended timeframe of treatment. In addition,

the request does not include dosing frequency or duration. The IW's response to this medication is not discussed in the documentation. The request is not medically necessary.

Motrin 400mg #60: 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): NSAIDs (non-steroidal anti-inflammatory drugs), NSAIDs, specific drug list & adverse effects.

Decision rationale: According to CA MTUS chronic pain guidelines, non-steroidal anti-inflammatory agents are "recommended as an option for short term symptomatic relief" for the treatment of chronic low back pain. Further recommendations are for the lowest dose for a minimal duration of time. Specific recommendations for ibuprofen (Motrin) state "sufficient clinical improvement should be observed to offset potential risk of treatment with the increase dose." The documentation does not support improvement of symptoms with NSAIDs currently prescribed. There is no documentation of pain relief or functional improvement specific to the use of this medications. Additionally, the request does include frequency and dosing of this medication. The request is medically not necessary.