

Case Number:	CM15-0201895		
Date Assigned:	10/20/2015	Date of Injury:	01/13/2015
Decision Date:	12/29/2015	UR Denial Date:	09/22/2015
Priority:	Standard	Application Received:	10/14/2015

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: California, Arizona
 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 is a 66-year-old male with a date of industrial injury 1-13-2015. The medical records indicated the injured worker (IW) was treated for lumbar sprain-strain; right fifth digit pain with flexion; right knee sprain-strain; right shoulder bursitis-tendinosis; left elbow sprain-strain; right hand, wrist sprain-strain. In the progress notes (8-31-15), the IW reported low back pain, right shoulder pain, right knee pain, right wrist pain, right hand pain and right small finger pain rated 8 out of 10; left elbow pain rated 5 out of 10 and headache pain rated 6 out of 10. His pain was increased from the 5-28-15 and 7-30-15 visits. The IW reported pain was improved with medications, therapy and topical creams and worsened by activities of daily living. On examination (8-31-15 notes), Jamar grip measurements were 22-24-20 (kg) on the right and 20-18-22 (kg) on the left. There was tenderness and spasms in the lumbar paraspinals and the quadratus lumborum. Treatments included occupational and physical therapy, Naproxen, topical Gabapentin 15%, Dextromethorphan 10% and Amitriptyline 4% (since at least 5-2015) and topical Flurbiprofen 25% and Cyclobenzaprine 2% (since at least 5-2015). The IW was allowed to work with restrictions. MRI right shoulder 7/6/2015 was reviewed and did not show evidence of calcific tendinitis, but there was evidence of acromioclavicular arthritis, subdeltoid/subacromial bursitis, and infraspinatus/subscapularis/supraspinatus tendinosis, A Request for Authorization dated 8-31-15 was received for physical therapy once week for four weeks; acupuncture two times a week for four weeks; shockwave therapy; MRI of the lumbar spine; functional improvement measurement with limited functional improvement measures using NIOSH standard testing 30-60 days; orthopedic consultation for the right shoulder, right

knee and left elbow; neurological spine consultation for the lumbar spine; Flurbiprofen 25%, Cyclobenzaprine 2%, 180 grams and Gabapentin 15%, Dextromethorphan 10%, Amitriptyline 4%, 180 grams. The Utilization Review on 9-22-15 non-certified the request for physical therapy once week for four weeks; shockwave therapy; MRI of the lumbar spine; functional improvement measurement with limited functional improvement measures using NIOSH standard testing 30-60 days; orthopedic consultation for the right shoulder, right knee and left elbow; neurological spine consultation for the lumbar spine; Flurbiprofen 25%, Cyclobenzaprine 2%, 180 grams and Gabapentin 15%, Dextromethorphan 10%, Amitriptyline 4%, 180 grams and modified the request for acupuncture two times a week for four weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy 1 time a week for 4 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

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

Decision rationale: The California MTUS recommends 8-10 sessions of physical therapy for various myalgias or neuralgias. Guidelines recommend fading of treatment frequency with ultimate transition to a home exercise program. ODG Guidelines recommend six visit clinical trials of physical therapy, and close monitoring of tolerance and progress to determine if the individuals are making positive gains, no gains, or negative response to therapy. There is no mention of how previous therapy served to reduce pain using validated measures, nor is there mention of improved function or ability to participate in activities of daily living. As such, this request is not medically necessary.

Acupuncture 2 times a week for 4 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment 2007.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment 2007.

Decision rationale: According to the MTUS guidelines, acupuncture can be considered when pain medications are not tolerated, or reduced. It may also be used as an adjunct to physical rehabilitation or surgical intervention to hasten functional recovery. Typical time frame needed to produce functional benefit is 3-6 sessions. In review of the records, it appears acupuncture was previously modified-certified for 2x4 sessions. Without knowing how previous acupuncture served to reduce pain, reduce consumption of pain medications, and/or increased function and ability to participate in activities of daily living, additional acupuncture cannot be considered. As such, this request is not medically necessary.

Functional improvement measurement with limited functional improvement measures using NIOSH standard testing 30-60 days: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Pain Chapter, online version, Functional Improvement Measures.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Functional Capacity Evaluations.

Decision rationale: Per the ODG, functional capacity evaluations (FCE) are recommended prior to admission to work hardening programs, with preference for assessments tailored to a specific job. Not recommended as a 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. Consider an FCE if: Case management is hampered by complex issues such as prior unsuccessful return to work attempts, conflicting medical reporting on precaution and/or fitness for modified work, and injuries that require detailed exploration of the workers abilities. There is no recent mention of complex issues such as prior unsuccessful return to work, and the request as submitted states 'one baseline.' The request lacks a clear documented rationale for service and as such, is not medically necessary.

Shockwave Therapy: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Elbow Chapter, Extracorporeal shockwave therapy (ESWT) and the Anthem Blue Cross: Medical Policy: Extracorporeal Shockwave Therapy for Orthopedic Conditions.

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

Decision rationale: The ODG note that extracorporeal shock wave therapy is recommended for patients whose pain from calcifying tendinitis of the shoulder has remained despite six months of standard treatment. There is no documented calcific tendinitis noted. Recent MRI confirms bursitis and tendinosis. This request does not coincide with applicable guidelines and as such, is not medically necessary.

MRI of lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Low Back-Lumbar and Thoracic (Online Version): MRI's (magnetic resonance imaging).

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

Decision rationale: Per California MTUS Guidelines, MRI is indicated if there are unequivocal objective findings that identify specific nerve compromise on neurologic examination in patients who do not respond to treatment and who would consider surgery an option. Lumbar MRI is the mainstay in the evaluation of myelopathy. In addition to diagnosing disc herniation, neoplastic and infectious processes can also be visualized using MRI. Within the records, there is no recent significant red flag finding on physical exam such as sensory deficit or weakness. There is spasm and tenderness to palpation, and no positive straight leg raise. There is no mention of how MRI will guide future management. This request is not medically necessary.

Orthopedic consultation for the right shoulder, right knee & left elbow: Overturned

Claims Administrator guideline: Decision based on MTUS General Approaches 2004, Section(s): Cornerstones of Disability Prevention and Management. Decision based on Non-MTUS Citation ACOEM Occupational Medicine Practice Guidelines: Independent Medical Examinations and Consultations, Chapter 7, pages 127-146.

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): General Approach, Initial Care, Follow-up Visits, Surgical Considerations, and Elbow Complaints 2007, Section(s): Recommendations, and Knee Complaints 2004, Section(s): General Approach, Initial Care, Follow-up Visits, Surgical Considerations.

Decision rationale: The CA MTUS Guidelines recommend a consultation to aid with diagnosis/prognosis and therapeutic management, recommend referrals to other specialists if a diagnosis is uncertain or exceedingly complex when there are psychosocial factors present, or when a plan or course of care may benefit from additional expertise. Within the records, this injured worker has dealt with chronic pain and this has apparently been unresponsive to medications, acupuncture, and physical therapy. Additional expertise in this setting is reasonable and an Orthopedic consult is therefore, medically necessary.

Neuro spine consult for the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS General Approaches 2004, Section(s): Cornerstones of Disability Prevention and Management. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (Online Version): Office Visits.

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

Decision rationale: The CA MTUS and the ODG guidelines recommend that patients can be referred to consultation with a pain specialist when the diagnosis is complex or when additional expertise will be beneficial to the medical management. Within the records, though the injured worker has significant tenderness to the low back, there are no red flags or neurological deficits

such as weakness, abnormal sensation, or abnormal reflexes to warrant specialty referral at this time, without further clarification. As such, this request at this time is not medically necessary.

Flurbiprofen 25%, Cyclobenzaprine 2% 180gms: Upheld

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

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

Decision rationale: Per MTUS guidelines, the use of topical analgesics in the treatment of chronic pain is largely experimental, and when used, is primarily recommended for the treatment of neuropathic pain when trials of first line treatments such as anti-convulsants and/or anti-depressants have failed. The guidelines go on to state that when any compounded product contains 1 medication that is not recommended, the compounded product as a whole is not recommended. This compound contains Flurbiprofen, an NSAID and Cyclobenzaprine, a CNS depressant and muscle relaxant that is not supported by the MTUS for topical use. Therefore, this request as a whole is not medically necessary.

Gabapentin 15%, Dextromethorphan 10%, Amitriptyline 4% 180gms: Upheld

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

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

Decision rationale: Per MTUS guidelines, the use of topical analgesics in the treatment of chronic pain is largely experimental, and when used, is primarily recommended for the treatment of neuropathic pain when trials of first line treatments such as anti-convulsants and/or anti-depressants have failed. The guidelines go on to state that when any compounded product contains 1 medication that is not recommended, the compounded product as a whole is not recommended. This compound contains Gabapentin and Amitriptyline, both of which are not supported by the MTUS for topical use. As such, this request is not medically necessary.