

Case Number:	CM15-0202649		
Date Assigned:	10/19/2015	Date of Injury:	08/28/2014
Decision Date:	12/03/2015	UR Denial Date:	10/07/2015
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: New York
 Certification(s)/Specialty: Anesthesiology

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 59 year old male, who sustained an industrial injury on 8-28-2014. The injured worker is undergoing treatment for: neck, back, upper and lower extremities. On 7-10-15, he reported low back pain. Physical examination revealed tenderness, decreased range of motion and negative straight leg raising bilaterally. On 8-11-15, he reported neck pain with radiation into the upper extremity rated 6-8 out of 10, low back pain with radiation into the right lower extremity rated 0-5 out of 10. He also reported anxiety, depression, and insomnia. Physical findings revealed tenderness, spasm and painful decreased range of motion to the neck; tenderness, and spasms to the thoracic spine; tenderness decreased range of motion and positive right seated straight leg raise bilaterally for the lumbar spine. The treatment and diagnostic testing to date has included: trigger point injections, home exercise program, and multiple sessions of physical therapy. Current work status: restricted. The request for authorization is for: x-ray of the cervical region; x-ray of the thoracic region; x-ray of the lumbar region; lumbar spine support; baseline functional improvement measures-muscle testing, manual neck, thoracic, lumbar quantity 3; baseline physical performance test or measurement of neck, thoracic, lumbar quantity 3; Gabapentin 15 percent-amitriptyline 4 percent-dextromethorphan 10 percent, 180 grams; Cyclobenzaprine 2 percent-Flurbiprofen 25 percent, 180 grams; acupuncture of neck, thoracic and lumbar quantity 8; and pharmacological gene analysis assay for medication therapy management quantity 7. The UR dated 10-7-2015: modified certification of acupuncture of neck, thoracic and lumbar quantity 4; non-certification of x-ray of the cervical region; x-ray of the thoracic region; x-ray of the lumbar region; lumbar spine support; baseline functional

improvement measures-muscle testing, manual neck, thoracic, lumbar quantity 3; baseline physical performance test or measurement of neck, thoracic, lumbar quantity 3; Gabapentin 15 percent-amitriptyline 4 percent-dextromethorphan 10 percent, 180 grams; Cyclobenzaprine 2 percent-Flurbiprofen 25 percent, 180 grams; and pharmacological gene analysis assay for medication therapy management quantity 7.

IMR ISSUES, DECISIONS AND RATIONALES

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

X-ray Cervical Region QTY 1: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004. Decision based on Non-MTUS Citation Work Loss Data Institute Official Disability Guidelines (ODG), Neck & Upper Back (Acute & Chronic) (updated 6/25/15), Radiographs (x-rays).

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

Decision rationale: The CA MTUS ACOEM Guidelines indicate that if neck symptoms persist beyond four to six weeks, further evaluation may be indicated. The injured worker has been complaining of neck pain since his injury on 08/24/2014. The criteria for ordering imaging studies are: emergence of a red flag; physiologic evidence of tissue injury or trauma or neurologic dysfunction; failure to progress in a strengthening program intended to avoid surgery; and clarification of the anatomy before an invasive procedure. The guidelines also indicate that "cervical radiographs are most appropriate for patients with acute trauma associated with midline vertebral tenderness, head injury, drug or alcohol intoxication, or neurologic compromise." There was no documentation of evidence of any of these criteria. Medical necessity for the requested x-rays has not been established. The requested x-rays are not medically necessary.

X-ray Thoracic Region QTY 1: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004. Decision based on Non-MTUS Citation Work Loss Data Institute Official Disability Guidelines (ODG), Neck & Upper Back (Acute & Chronic) (updated 6/25/15), Radiographs (x-rays).

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

Decision rationale: The CA MTUS guidelines do not address thoracic spine x-rays. The ODG does not recommend x-rays of in absence of red flags for serious spinal pathology, even if the pain persists for greater than 6 weeks. Thoracic spine x-rays are recommended for pain, tenderness, severe trauma, a neurological deficit, sudden onset of myelopathy, myelopathy of infectious disease patient and post-surgical fusion for evaluation. There is no indication for

thoracic spine films one year after the reported thoracic sprain/strain. Medical necessity for the requested x-rays has not been established. The requested x-rays are not medically necessary.

X-ray Lumbar Region QTY 1: Upheld

Claims Administrator guideline: Decision based on MTUS Low 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) Lumbar spine films.

Decision rationale: Lumbar spine radiography should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least 6 weeks. According to the American College of Radiology, "It is now clear from previous studies that uncomplicated acute low back pain is a benign, self-limited condition that does not warrant any imaging studies." Indications for plain x-rays include, lumbar spine trauma with pain and tenderness, neurologic deficit, or chance of a fracture. In addition, x-rays are indicated for uncomplicated low back pain, steroids, osteoporosis, age over 70, suspicion of cancer or infection; myelopathy and post-surgery to evaluate the status of a fusion. In this case, the patient underwent previous lumbar spine x-rays and a MRI of the lumbar spine. There is no indication for repeat lumbar spine films one year after the reported injury. Medical necessity for the requested x-rays has not been established. The requested x-rays are not medically necessary.

Lumbar Spine Support QTY 1: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Work Loss Data Institute Official Disability Guidelines (ODG), Low Back Lumbar & Thoracic (Acute & Chronic) updated 9/22/15, lumbar supports.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Initial Care. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Lumbar supports.

Decision rationale: According to the ODG, lumbar supports are recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific LBP (very low-quality evidence, but may be a conservative option). According to MTUS/ACOEM guidelines, lumbar support braces have not been shown to have lasting benefit beyond the acute phase of symptom relief. In this case, this patient has had chronic low back pain complaints, and a lumbar support brace is not warranted. Medical necessity for the requested lumbar support brace has not been supported or established. The requested item is not medically necessary.

Baseline Functional Improvement Measures-muscle testing, manual neck, thoracic, lumbar: Upheld

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

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

Decision rationale: Functional improvement measures are recommended. Restoration of function should be the primary measure of treatment success. Functional improvement measures should be used over the course of treatment to demonstrate progress in return to functionality, and to justify further use of ongoing treatment methods. They 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, pain scales, return-to-work, etc.); Physical Impairments (e.g., joint ROM, muscle flexibility, strength, or endurance deficits), and Approach to Self-Care and Education (e.g., reduced reliance on other treatments, modalities, or medications, such as reduced use of painkillers). In this case, the request is for functional improvement measures-muscle testing, manual neck, thoracic, and lumbar area. According to the MTUS and the ODG, muscle testing is not a separate procedure. Muscle testing is typically performed during a comprehensive physical examination. Medical necessity for the requested testing has not been established. The requested functional improvement measures-muscle testing, manual neck, thoracic, lumbar is not medically necessary.

Baseline physical performance test or measurement neck, thoracic, lumbar QTY 3: Upheld

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

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Work-Relatedness. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Functional improvement measures.

Decision rationale: According to the CA MTUS and the ODG, functional improvement measures are recommended. Restoration of function should be the primary measure of treatment success. Functional improvement measures should be used over the course of treatment to demonstrate progress in return to functionality, and to justify further use of ongoing treatment methods. The guidelines recommend assessment repeatedly over the course of the treatment but do not have a specific physical performance test at baseline. In this case, the patient is on modified duty which includes specified restrictions. Medical necessity for the requested testing has not been established. The requested Baseline physical performance test or measurement neck, thoracic, lumbar is not medically necessary.

Gabapentin 15%, Amitriptyline 4%, Dextromethorphan 10% 180g: 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: 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 (for example including, NSAIDs, opioids, capsaicin, muscle relaxants, local anesthetics and/or antidepressants). Guidelines indicate that any compounded product that contains at least 1 non-recommended drug (or drug class) is not recommended for use. In this case, the topical analgesic compound contains: Gabapentin 15%, Amitriptyline 4%, and Dextromethorphan 10%. In this case, there is no documentation provided necessitating this compounded topical analgesic. There is no documentation of intolerance to other previous oral medications. Flurbiprofen, used as a topical NSAID, has been shown 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. In addition, there are no clinical studies to support the safety or effectiveness of Flurbiprofen in a topical delivery system (excluding ophthalmic). Gabapentin is not recommended as a topical agent per CA MTUS Guidelines. Medical necessity for the requested topical medication has not been established. The requested treatment is not medically necessary.

Cyclobenzaprine 2%, Flurbiprofen 25% 180g: 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: 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 1 non-recommended drug (or drug class) is not recommended for use. The requested topical analgesic compound for this patient contains: Flurbiprofen 25% and Cyclobenzaprine 2%. There are no clinical studies to support the safety or effectiveness of Flurbiprofen in a topical delivery system (excluding ophthalmic). The MTUS guidelines state that Flurbiprofen, lidocaine, and/or muscle relaxants (Cyclobenzaprine in this case) are not recommended for topical applications. Medical necessity for the requested topical analgesic compounded medication, for muscular pain, has not been established. The requested topical compound is not medically necessary.

Pharmacological Gene Analysis Assay for Medication Therapy Management: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Work Loss Data Institute Official Disability Guidelines (ODG), Pain (Chronic), updated 7/15/15.

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

Decision rationale: According to the ODG, genetic (cytokine DNA) testing for resistance to opioids is not a standard practice in pain management. There is no support for this laboratory study in the ODG. There is no current evidence to support the use of cytokine DNA testing for the diagnosis of pain, including chronic pain. Medical necessity for the requested laboratory study has not been established. The requested laboratory study is not medically necessary.

Acupuncture neck, thoracic & lumbar QTY 8: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment 2007.

Decision rationale: The California MTUS Acupuncture guidelines apply to all acupuncture requests, for all body parts and for all acute or chronic, painful conditions. According to the Acupuncture Medical Treatment Guidelines, acupuncture is used as an option when pain medication is reduced or not tolerated. It may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten recovery. The treatment guidelines support acupuncture treatment to begin as an initial treatment of 3-6 sessions over no more than two weeks. If functional improvement is documented, as defined by the guidelines, further treatment will be considered. In this case, the requested acupuncture sessions (8 sessions) exceed the recommended 3-6 sessions in up to 2 weeks. Medical necessity of the requested acupuncture has not been established. The requested services are not medically necessary.