

<b>Case Number:</b>	CM15-0028090		
<b>Date Assigned:</b>	02/20/2015	<b>Date of Injury:</b>	09/21/2004
<b>Decision Date:</b>	03/31/2015	<b>UR Denial Date:</b>	01/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/13/2015

### 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

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:

The injured worker is a 57 year old male, who sustained an industrial injury on September 21, 2004. The diagnoses have included elbow epicondylitis, bilateral shoulder right greater than left impingement, cervical Discopathy C5-C6, lumbar sprain/strain, lumbar spine Discopathy, bilateral carpal tunnel syndrome, anxiety, depression and asthma. Currently, the injured worker complains of neck, low back, bilateral shoulders and bilateral hands pain, described as burning and stabbing in the neck, with numbness and pins and needles sensation in the bilateral shoulders and arms he also complains of aching, burning and stabbing pain in the back and bilateral legs with numbness and pins and needles sensation. In a progress note dated January 7, 2015, the treating provider reports examination of the cervical spine there is tenderness at the occipital insertion of the paracervical musculature with mild tenderness bilaterally in the trapezii and the midline base of the cervical spine is tender. The range of motion there is discomfort with flexion and extension and limited range of motion. The shoulder examination reveals tenderness with palpation in the sternoclavicular joint, anterior capsule and acromioclavicular joint and decreased range of motion with crepitus present on motion. The bilateral hands are positive for Tinel's sign and Phalen's, lumbar spine inspection there is tenderness to palpation from the thoracolumbar spine down to the base of the pelvis. The buttocks is tender and unable to fully squat due to pain, there is some tenderness on stress of the pelvis which indicates mild sacroiliac joint symptomology. On January 15, 2015 Utilization Review non-certified a Magnetic resonance imaging of right shoulder, Pro-stim 5.0 for spine, and Gabapentin/Cyclobenzaprine/Ketoprofen/Capsaicin/Menthol/Camphor cream 10/4/10/.0375/5/2

percent apply 1-2 grams to affected area, noting, Medical Treatment Utilization Schedule Guidelines , American College of Occupational and Environmental Medicine and Official Disability Guidelines was cited.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Magnetic Resonance Imaging Right Shoulder: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 208. Decision based on Non-MTUS Citation Official Disability Guidelines Treatment Index 7th Edition (web) 2012 Shoulder: Indications for Imaging - Magnetic Resonance Imaging

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): Chapter 9, Shoulder Complaints, Special Studies and Diagnostic Considerations, page 209.

**Decision rationale:** Guidelines state routine MRI or arthrography is not recommended without surgical indication such as clinical findings of rotator cuff tear. It may be supported for patients with limitations of activity after four weeks and unexplained physical findings, such as effusion or localized pain (especially following exercise), imaging may be indicated to clarify the diagnosis and assist reconditioning; however, this has not been demonstrated with negative impingement sign and lack of neurological deficits. Criteria for ordering imaging studies such include Emergence of a red flag; Physiologic evidence of tissue insult or neurologic dysfunction; Failure to progress in a strengthening program intended to avoid surgery; Clarification of the anatomy prior to an invasive procedure. Physiologic evidence may be in the form of definitive neurologic findings on physical examination and electrodiagnostic studies. Unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist; however, review of submitted medical reports have not adequately demonstrated the indication for the MRI. When the neurologic examination is less clear, further physiologic evidence of nerve dysfunction can be obtained before ordering an imaging study. The Magnetic Resonance Imaging Right Shoulder is not medically necessary and appropriate.

#### **Pro-Stim 5.0 for Spine: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM,Chronic Pain Treatment Guidelines Criteria for the use of TENS.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy, TENS for chronic pain, pages 114-117.

**Decision rationale:** Per MTUS Chronic Pain Treatment Guidelines, ongoing treatment is not advisable if there are no signs of objective progress and functional restoration has not been demonstrated. Specified criteria for the use of TENS Unit include trial in adjunction to ongoing

treatment modalities within the functional restoration approach as appropriate for documented chronic intractable pain of at least three months duration with failed evidence of other appropriate pain modalities tried such as medication. From the submitted reports, the patient has received extensive conservative medical treatment to include chronic analgesics and other medication, extensive physical therapy, activity modifications, yet the patient has remained symptomatic and functionally impaired. There is no documentation on whether this unit is for rental or purchase, nor is there any documented short-term or long-term goals of treatment with the Stim unit. There is no evidence for change in functional status, increased in ADLs, decreased VAS score, medication usage, or treatment utilization from the treatment already rendered. The Pro-Stim 5.0 for Spine is not medically necessary and appropriate.

**Gabapentin/ Cyclobenzaprine/ Ketprofen/ Capsaicin/ Menthol/ Camphor Cream 10/4/10/0.375/5/2% 240 gm:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112. Decision based on Non-MTUS Citation Official Disability Guidelines; Pain; Topical Agents

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics, page(s) 111-113.

**Decision rationale:** Per MTUS Chronic Pain Guidelines, the efficacy in clinical trials for topical analgesic treatment modality has been inconsistent and most studies are small and of short duration. These medications may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. There is little evidence to utilize topical compound analgesic over oral NSAIDs or other pain relievers for a patient with multiple joint pain without contraindication in taking oral medications. Submitted reports have not adequately demonstrated the indication or medical need for this topical analgesic to include a compounded NSAID, muscle relaxant, anti-epileptic over oral formulation for this chronic injury without documented functional improvement from treatment already rendered. Guidelines do not recommend long-term use of NSAID without improved functional outcomes attributable to their use. Additionally, Guidelines do not recommend long-term use of this muscle relaxant and anti-seizure medications for this chronic injury without improved functional outcomes attributable to their use. The Gabapentin/ Cyclobenzaprine/ Ketprofen/ Capsaicin/ Menthol/ Camphor Cream 10/4/10/0.375/5/2% 240 gm is not medically necessary and appropriate.