MAXIMUS Federal Services

Case Number:	CM15-0056969		
Date Assigned:	04/17/2015	Date of Injury:	08/01/2009
Decision Date:	11/13/2015	UR Denial Date:	03/13/2015
Priority:	Standard	Application Received:	03/25/2015

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 49 year old female who sustained an industrial injury on 8-1-09. The injured worker reported chronic neck, shoulder and low back pain. A review of the medical records indicates that the injured worker is undergoing treatments for chronic neck pain, degenerative cervical spondylosis, myofascial pain syndrome, pain disorder with psychological general medical condition, degenerative osteoarthritis, and degenerative spondylosis lumbar spine. Provider documentation dated 3-10-15 indicates the injured worker was with "chronic pain". Provider documentation dated 4-26-15 noted the work status as temporary totally disabled. Treatment has included analgesics, Norco, Wellbutrin, and Orphenadrine. Examination dated 5-20-15 was notable for dorsolateral shoulder tenderness to palpation, pain with range of motion. The treating physician indicates that the urine drug test was performed 3-10-15. The original utilization review (3-13-15) denied a cervical pillow, Trazodone 50 milligrams quantity of 60, LidoPro cream, consultation with pain management, spinal surgery consultation, electromyography left lower extremity, electromyography right lower extremity, nerve conduction velocity study left lower extremity, nerve conduction velocity study right lower extremity and elbow pad quantity of 2.

IMR ISSUES, DECISIONS AND RATIONALES

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

Cervical pillow: 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) Collars (cervical).

Decision rationale: A cervical pillow is used for neck support while sleeping. They may be appropriate for use postoperative use or for fracture indications. However, cervical collars/pillows are not recommended for neck sprains. In this case, the injured worker has a whiplash associated disorder. Rest and immobilization using collars are less effective and are not indicated for this patient's condition. Medical necessity for the requested item has not been established. The requested item is not medically necessary.

Trazodone 50mg #60: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

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

Decision rationale: Trazodone (Desyrel) is recommended as an option for insomnia, only for patients with potentially coexisting mild psychiatric symptoms such as depression or anxiety. It is unrelated to tricyclic or tetracyclic anti-depressants and has some action as an anxiolytic. In this case, there is no documentation of a history of depression, anxiety or insomnia. Medical necessity of the requested medication has not been established. The requested medication is not medically necessary.

LidoPro cream: 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: According to the California MTUS Guidelines, topical analgesics are primarily recommended for neuropathic pain when trials of anti-depressants and anti-convulsants 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 anti-depressants. 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 requested topical analgesic compound, LidoPro cream, contains: Capsaicin, Lidocaine, Menthol and Methyl Salicylate. MTUS guidelines state that Lidocaine is not recommended for topical application for treatment of neuropathic pain. Capsaicin is recommended only as an option in patients who have not responded to, or are intolerant to other treatments. In addition, there is no indication that the already prescribed Gabapentin has failed, to warrant this requested topical analgesic agent. Medical necessity for the requested topical analgesic compound has not been established. The requested topical compound is not medically necessary.

Consultation with pain management: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM OMPG Second Edition (2004), Chapter 6 page 112 regarding Pain, Suffering, and the Restoration of Function.

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

Decision rationale: According to the CA MTUS/ACOEM, a consultation is indicated to aid in the diagnosis, prognosis, and therapeutic management, determination of medical stability, and permanent residual loss and/or, the injured worker's fitness to return to work. In this case, there is no specific rationale identifying the medical necessity of the requested Pain Management consultation. According to the guidelines, evaluation and treatment of an injured worker can be handled safely and effectively by a primary care provider in the absence of red flags. In this case, a Pain Management consultation was previously approved and there is no documentation indicating why another consultation is indicated at this time. Medical necessity for the requested Pain Management consultation is not established. The requested consultation is not medically necessary.

Spinal Surgery consultation: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

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

Decision rationale: According to the CA MTUS/ACOEM, a consultation is indicated to aid in the diagnosis, prognosis, and therapeutic management, determination of medical stability, and permanent residual loss and/or, the injured worker's fitness to return to work. In this case, there is no specific rationale identifying the medical necessity of the requested Spine Surgery consultation. According to the guidelines, evaluation and treatment of an injured worker can be handled safely and effectively by a primary care provider in the absence of red flags. In this case, there is no specific indication for a spine surgery consultation. Medical necessity for the requested Spine Surgery consultation has not been established. The requested consultation is not medically necessary.

EMG Left Lower Extremity: Upheld

Claims Administrator guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Diagnostic Criteria, Special Studies, Summary. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) EMG/Nerve Conduction Studies.

Decision rationale: There is no documentation provided necessitating EMG testing of the left lower extremity. According to the ODG, Electromyography (EMG) and nerve conduction studies are an extension of the physical examination. They can be useful in adding in the diagnosis of peripheral nerve and muscle problems. This can include neuropathies, entrapment neuropathies,

radiculopathies, and muscle disorders. According to ACOEM Guidelines, needle EMG and H-reflex tests to clarify nerve root dysfunction are recommended for the treatment of low back disorders. In this case, there were no physical exam abnormalities of the left lower extremity. Medical necessity for the requested studies have not been established, as guideline criteria have not been met. The requested studies are not medically necessary.

EMG Right Lower Extremity: Upheld

Claims Administrator guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Diagnostic Criteria, Special Studies, Summary. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) EMG/Nerve Conduction Studies.

Decision rationale: There is no documentation provided necessitating EMG testing of the left lower extremity. According to the ODG, Electromyography (EMG) and nerve conduction studies are an extension of the physical examination. They can be useful in adding in the diagnosis of peripheral nerve and muscle problems. This can include neuropathies, entrapment neuropathies, radiculopathies, and muscle disorders. According to ACOEM Guidelines, needle EMG and H-reflex tests to clarify nerve root dysfunction are recommended for the treatment of low back disorders. In this case, there were no physical exam abnormalities of the right lower extremity. Medical necessity for the requested studies have not been established, as guideline criteria have not been met. The requested studies are not medically necessary.

NCV Left Lower Extremity: Upheld

Claims Administrator guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Diagnostic Criteria, Special Studies, Summary. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Nerve Conduction Studies.

Decision rationale: The request for diagnostic test NCV for the left lower extremity is not medically necessary. According to the ACOEM Guidelines, electromyography (EMG) and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle, focal neurologic dysfunction in patients with neck or arm problems, or both, lasting more than 3 to 4 weeks. The ODG further states that nerve conduction studies are recommended if the EMG is not clearly radiculopathy or clearly negative, or to differentiate radiculopathy from other neuropathies or non-neuropathic processes if other diagnoses may be likely based on the clinical exam. There is minimal justification for performing nerve conduction studies when a patient is already presumed to have symptoms on the basis of radiculopathy. In this case, there is no documentation of any objective clinical findings or any neurological deficits to support the requested NCV of the left lower extremity. Medical necessity for the requested studies has not been established. The requested studies are not medically necessary.

NCV Right Lower Extremity: Upheld

Claims Administrator guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Diagnostic Criteria, Special Studies, Summary. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Nerve Conduction Testing.

Decision rationale: The request for diagnostic test NCV for the right lower extremity is not medically necessary. According to the ACOEM Guidelines, electromyography (EMG) and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle, focal neurologic dysfunction in patients with neck or arm problems, or both, lasting more than 3 to 4 weeks. The ODG further states that nerve conduction studies are recommended if the EMG is not clearly radiculopathy or clearly negative, or to differentiate radiculopathy from other neuropathies or non-neuropathic processes if other diagnoses may be likely based on the clinical exam. There is minimal justification for performing nerve conduction studies when a patient is already presumed to have symptoms on the basis of radiculopathy. In this case, there is no documentation of any objective clinical findings or any neurological deficits to support the requested NCV of the right lower extremity. Medical necessity for the requested studies has not been established. The requested studies are not medically necessary.

Elbow pad, #2: 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) Elbow Splinting.

Decision rationale: According to the ODG, elbow splinting is recommended for cubital tunnel syndrome (ulnar nerve entrapment), including a splint or foam elbow pad worn at night (to limit movement and reduce irritation), and/or an elbow pad (to protect against chronic irritation from hard surfaces). Under study for epicondylitis. No definitive conclusions can be drawn concerning effectiveness of standard braces or splints for lateral epicondylitis. In this case, the elbow has not been accepted as being occupationally related. Medical necessity for the requested item has not been established. The requested item is not medically necessary.