

Case Number:	CM15-0082683		
Date Assigned:	05/05/2015	Date of Injury:	10/07/2008
Decision Date:	09/15/2015	UR Denial Date:	03/27/2015
Priority:	Standard	Application Received:	04/30/2015

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: Internal 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 44 year old female patient who sustained an industrial injury on 10/07/2008. She had initial acute onset of a pulling sensation in her arms, neck strain, along with left shoulder and back pains. That first night after the injury she did not go for triaging, and took Tylenol. The following day she attempted a shift of work but proved unable to function secondary to pain. She was seen in an emergency room given a topical analgesic, and placed on modified work duty. Thereafter, she underwent radiography and magnetic resonance imaging and was prescribed a course of physical therapy. Treatment rendered to include: oral analgesia, topical analgesia, physical therapy, epidural injection, isotherapy and hospitalization. She was taking off of all medications secondary to elevated liver enzymes, and subsequently, on 11/26/2010 she underwent left shoulder arthroscopy treating tendonitis. There were additional physical therapy sessions, aquatic therapy course and the onset of psychological symptoms secondary to chronic pain. A primary treating office visit dated 12/15/2014 reported the patient with subjective complaint of cervical spine, left shoulder, left elbow, low back, bilateral hips, and bilateral knee pains. She reports receiving medications form another provider. Objective findings showed lumbar spine with limited range of motion. There was a positive straight leg raise on the left and positive Kemp's bilaterally. The left hip had limited range of motion and positive Patrick/Fabere on the left. The assessment reported: cervical spine disc protrusion, left shoulder rotator cuff tear, lumbago, rule out fibromyalgia, and rule out chronic pain syndrome. The patient is pending a rheumatology consultation ruling out fibromyalgia versus chronic pain syndrome. The plan of care involved: recommending an orthopedic spine consultation, cervical

spine durable equipment, and pain management follow up. She is to remain temporary totally disabled for 45 days. She will return for follow up in 6 weeks. A more recent interventional pain management follow up visit dated 02/02/2015 reported current complaint of cervical spine, lumbar spine pain; along with the cervical spine pain radiating to the thoracic spine and bilateral shoulders accompanied with additional stiffness. She notes the pain had increased since the last visit. Objective findings showed her with antalgic gait to the left. There is tenderness to palpation over the lumbar paraspinal muscles. In addition, the assessment noted the patient guarding, and with moderate tenderness over the lumbar facets. She is positive for sacroiliac tenderness, Fabere's/Patrick, sacroiliac thrust, and Yeoman's tests. There is anterior left hip pain noted over the greater trochanter, and over the medial and lateral joint lines. The assessment noted: cervical strain/sprain; fibromyalgia; lumbar sprain/strain; lumbar facet syndrome; post annular tear of the intervertebral disc; left sacroiliac joint arthropathy, and left hip strain/sprain. The patient is participating in daily exercise, and stretches. The plan of care noted pending response for bilateral medial branch blocks, recommending a left sacroiliac injection, and a left transforaminal injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI (magnetic resonance imaging) Cervical Spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 165-194.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177 Neck and Upper Back Complaints, Special Studies and Diagnostic and Treatment Considerations.

Decision rationale: MTUS recommends spine x rays in patients with neck pain only when there is evidence of red flags for serious spinal pathology. Imaging in patients who do not respond to treatment may be warranted if there are objective findings that identify specific nerve compromise on the neurologic examination and if surgery is being considered as an option. Documentation fails to show objective clinical evidence of specific nerve compromise on the neurologic examination or acute exacerbation of the injured worker's symptoms to establish the medical necessity for MRI. The request for MRI (magnetic resonance imaging) Cervical Spine is not medically necessary.

MRI (magnetic resonance imaging) Left Hip: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip Replacement Chapter, MRI (magnetic resonance imaging).

Decision rationale: Per ODG, Hip Magnetic resonance imaging (MRI) is indicated in patients suspected of having Osseous, articular or soft-tissue abnormalities, Osteonecrosis, Occult acute and stress fracture, Acute and chronic soft-tissue injuries or Tumors. Documentation provided for review indicates that the injured worker complains of ongoing left hip pain. At the time of the requested service under review, there is lack of objective evidence indicating a significant change in symptoms or clinical findings to suspect pathology that would establish the medical necessity for MRI. With guidelines not being met, the request for MRI (magnetic resonance imaging) Left Hip is not medically necessary.

Urology Evaluation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation CA MTUS ACOEM Chapter 7: Independent Medical Examinations and Consultations.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 92 Referrals.

Decision rationale: MTUS states that a referral may be appropriate if the practitioner is uncomfortable with treating a particular cause of delayed recovery or has difficulty obtaining information or agreement to a treatment plan. Depending on the issue involved, it often is helpful to "position" a behavioral health evaluation as a return-to-work evaluation. The goal of such an evaluation is functional recovery and return to work. Documentation indicates that the injured worker complains of urinary incontinence. Physician reports fail to demonstrate details of initial evaluation and management recommended by the primary treating physician to establish the medical necessity for Specialty Consult. The request for Urology Evaluation is not medically necessary.

Aquatic therapy, Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic therapy Page(s): 22.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic therapy, Exercise, Physical Medicine Page(s): 22, pg 46, pg 98 & 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Aquatic therapy, Low Back Chapter.

Decision rationale: MTUS states that exercise programs, including aerobic conditioning and strengthening, are superior to treatment programs that do not include exercise. A therapeutic exercise program is recommended at the start of any treatment or rehabilitation program, unless exercise is contraindicated. MTUS and ODG guidelines recommend 10 physical therapy visits over 8 weeks for medical management of Lumbar sprains and strains and Intervertebral disc disorders without myelopathy. As time goes, one should see an increase in the active regimen of care or decrease in the passive regimen of care and a fading of treatment of frequency (from up to 3 or more visits per week to 1 or less). MTUS recommends aquatic therapy (including

swimming) as an optional form of exercise therapy, where available, as an alternative to land-based physical therapy. It is specifically recommended where reduced weight bearing is desirable, for example extreme obesity, being that it can minimize the effects of gravity. Per guidelines, the treatment should be monitored and administered by medical professionals. Documentation fails to demonstrate a clinical need for this injured worker to be provided reduced weight bearing to establish the medical necessity for an optional form of exercise therapy. The request for Aquatic therapy, Lumbar Spine to the lumbar spine is not medically necessary by MTUS.

Lidoderm patches (unspecified): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

Decision rationale: Lidocaine is recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy, including tri-cyclic or SNRI anti-depressants or an anti-epileptic drug. Per guidelines, further research is needed to recommend Lidoderm for the treatment of chronic neuropathic pain disorders other than post-herpetic neuralgia. Physician reports fail to demonstrate supporting evidence of significant improvement in the injured worker's pain to establish the medical necessity for ongoing use of Lidoderm patch. The request for Lidoderm patches (unspecified) is not medically necessary by lack of meeting MTUS criteria.

Compound Cream: Flurbiprofen 20% Baclofen 2% Dexamethasone 2% Menthol 2% Camphor 2% Capsaicin 0.0375% Hyaluronic Acid 0.20% - 180 grams: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

Decision rationale: MTUS states that use of topical analgesics is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many of these agents. Flurbiprofen is not FDA approved for topical application. MTUS provides no evidence recommending the use of topical Menthol or Camphor. Furthermore, MTUS does not recommend muscle relaxants as topical agent. Per guidelines, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The request for Compound Cream: Flurbiprofen 20% Baclofen 2% Dexamethasone 2% Menthol 2% Camphor 2% Capsaicin 0.0375% Hyaluronic Acid 0.20% - 180 grams is not medically necessary by MTUS.