

<b>Case Number:</b>	CM14-0124169		
<b>Date Assigned:</b>	08/08/2014	<b>Date of Injury:</b>	02/19/2014
<b>Decision Date:</b>	10/20/2014	<b>UR Denial Date:</b>	07/07/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/06/2014

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations

### 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 patient is a 47 year old female who sustained an industrial injury on 2/19/2014. According to the submitted records, the patient is treating for chronic cervical, lumbar and bilateral shoulder pain. Treatment has included work modifications, oral and topical analgesics, physical therapy, acupuncture, chiropractic, and cortisone injections. She is working full duties. Several prior peer reviews have been performed regarding multiple requests. The 6/10/2014 peer review non-certified all the requests. The appeal peer review on 7/7/2014 rendered modification of the request for chiropractic to allow 6 treatments to the cervical, lumbar and bilateral shoulders, and non-certified bilateral cock-up wrist braces, cycloketolido, psychiatric/psychology consult, lumbar-sacral orthosis, EMG/NCV of bilateral upper extremities and cervical spine, and right shoulder injection. Recently, the 8/7/2014 peer review recommended certification of 12 PT sessions to the cervical, lumbar, both shoulder and both wrists, 6 acupuncture sessions cervical, lumbar, both shoulder and both wrists, psychiatric/psychologist evaluation. The requests for right wrist brace, lumbar corset brace, and gabaketolido were non-certified. The 7/11/2014 PR-2 indicates the patient complains of 8/10 cervical pain, she changes positions to decrease pain, and pain increases with prolonged positions. Occasional radicular symptoms to RUE. Right hand numbness, intermittent symptoms in left hand. EMG/NCV scheduled for 8/21/2014. She reports improved right shoulder pain, injection helped for a few days. Has intermittent lumbar spine pain, 4/10. She indicates mild improvement since last exam. Physical examination findings include some guarding, tenderness, spasm, normal gait, 5/5 motor strength, positive Tinel's and Phalen's, some limited ROM. The 7/11/2014 report indicates request for authorization of PT 3x4 to the cervical, shoulders, wrists and lumbar spine, acupuncture 2x6 to the cervical, shoulders, wrists and lumbar spine, right wrist brace, lumbar corset brace, SolarCare FIR heating system to cervical and lumbar spine, and gabaketolido. A shoulder procedure note dated 7/31/2014

indicates the patient was administered #2 injection to the right shoulder. The first injection (6/11/2014) provided 3 days relief.

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

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

**6 Chiropractic treatments to the cervical lumbar spine and bilateral shoulders, includes initial appointment, follow up exams and treatment may, outcome assessment, VsNCT's:**  
Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-59.

**Decision rationale:** The CA MTUS guidelines recommend Manual therapy & manipulation for chronic pain if caused by musculoskeletal conditions. Manual Therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of Manual Medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Low back: Recommended as an option. Therapeutic care - Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Elective/maintenance care - Not medically necessary. Recurrences/flare-ups - Need to reevaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months. The medical records indicate the patient already been authorized and undergone chiropractic treatment to the spine and bilateral shoulders. There lacks documentation of how many sessions the patient has completed to date. Additionally, there lacks clear evidence of objective functional improvement of rendered care. At this juncture, the medical necessity of additional chiropractic care has not been established. The request is non-certified.

**1 Bilateral wrist cock up:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 264.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 264-266.

**Decision rationale:** The medical records do not appear to detail subjective complaints and objective findings with diagnosis that would warrant bilateral cock-up wrist brace. In general, when treating with a splint in CTS, scientific evidence supports the efficacy of neutral wrist splints. The medical necessity for cock-up brace is not established. The request is non-certified.

**Cyclobenzaprine/Ketoprofen/Lidocaine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics.

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

**Decision rationale:** The CA MTUS state only Lidocaine in the formulation of Lidoderm patch may be considered for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as Gabapentin or Lyrica). The guidelines state no other commercially approved topical formulations of Lidocaine are indicated for neuropathic pain. The medical records do not establish a diagnosis of diabetic neuropathy or post-herpetic neuralgia. Topically applied Lidocaine is not recommended for non-neuropathic pain. The patient tolerates standard oral medications. Additionally, Ketoprofen is not FDA-approved for a topical application. It has an extremely high incidence of photo-contact dermatitis. Only FDA approved are recommended. Furthermore, muscle relaxants are not recommended for topical application. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The medical records do not establish this topical product is medically necessary. The request is non-certified.

### **1 Psychiatric/Psychology consult:**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 387.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Psych Evaluations Page(s): 100-101. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 7 - Independent Medical Examinations and Consultations, page 503

**Decision rationale:** As per CA MTUS/ACOEM guidelines, consultation is recommended to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work. The CA MTUS recommends psychological evaluations. The guidelines state psychological evaluations are generally accepted, well-established diagnostic procedures not only with selected use in pain problems, but also with more widespread use in chronic pain populations. Diagnostic evaluations should distinguish between conditions that are preexisting, aggravated by the current injury or work related. Psychosocial evaluations should determine if further psychosocial interventions are indicated. It appears that the prior peer review on 8/7/2014 addressed this request, and certified the patient for a psychiatric/psychologist evaluation. Therefore, the request is not medically necessary, as there is no basis to certify this request, as would be redundant. The request is non-certified.

**Lumbar-sacral orthosis:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 1 Prevention, Chapter 12 Low Back Complaints Page(s): 9, 297. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Lumbar Supports

**Decision rationale:** The guidelines state, "There is no evidence for the effectiveness of lumbar supports in preventing back pain in industry." "Lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief." There is no evidence to substantiate back supports are effective in preventing back pain. These devices have not been shown to have any lasting benefit beyond the acute phase of symptom relief. A lumbar support is not recommended under the guidelines. At this juncture, the use of devices should be avoided, as these have not been shown to provide any notable benefit, and prolonged use has potential to cause weakness and atrophy of the paraspinal musculature. The medical necessity of a lumbosacral orthosis is not established. The request is non-certified.

**EMG bilateral upper extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178. Decision based on Non-MTUS Citation Official Disability Guidelines Neck and Upper Back

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178-179. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back, Electromyography, (EMG)

**Decision rationale:** As per CA MTUS/ACOEM guidelines, "unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist." Further guidelines indicate "electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks." The patient reports she is improving. She has also been authorized additional conservative therapies. The medical records do not establish she has persistent symptoms and objective findings of neuropathy and/or radiculopathy that have failed to improve with conservative measures. The request is non-certified.

**NCV bilateral upper extremities:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back, Nerve conduction studies (NCS)

**Decision rationale:** As per CA MTUS/ACOEM guidelines, "unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist." Further guidelines indicate "electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks." The patient reports she is improving. She has also been authorized additional conservative therapies. The medical records do not establish she has persistent symptoms and objective findings of neuropathy and/or radiculopathy that have failed to improve with conservative measures. The request is non-certified.

**EMG cervical spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178-179. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back, Electromyography, (EMG)

**Decision rationale:** As per CA MTUS/ACOEM guidelines, "unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist." Further guidelines indicate "electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks." The patient reports she is improving. She has also been authorized additional conservative therapies. The medical records do not establish she has persistent symptoms and objective findings of neuropathy and/or radiculopathy that have failed to improve with conservative measures. The request is non-certified.

**NCV cervical spine:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 178-179. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back, Nerve conduction studies (NCS)

**Decision rationale:** As per CA MTUS/ACOEM guidelines, "unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist." Further guidelines indicate "electromyography (EMG), and nerve conduction velocities (NCV), including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks." The patient reports she is improving. She has also been authorized additional

conservative therapies. The medical records do not establish she has persistent symptoms and objective findings of neuropathy and/or radiculopathy that have failed to improve with conservative measures. The request is non-certified.

**Injection to right shoulder:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 209, 211, 213. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder, Steroid injections

**Decision rationale:** The CA MTUS ACOEM guidelines state invasive techniques have limited proven value. If pain with elevation significantly limits activities, a subacromial injection of local anesthetic and a corticosteroid preparation may be indicated after conservative therapy (i.e., strengthening exercises and non-steroidal anti-inflammatory drugs) for two to three weeks. The evidence supporting such an approach is not overwhelming. The medical records do not provide evidence of significant pain and functional deficits and failure on non-invasive care. The medical necessity of right shoulder injection is not established. The request is non-certified.

**Functional Capacity Program:** 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:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Chronic pain programs (functional restoration program.

**Decision rationale:** The assumption is that the request is similar to a functional restoration program. In which case, the CA MTUS states chronic pain programs (functional restoration programs) are recommended where there is access to programs with proven successful outcomes, for patients with conditions that put them at risk of delayed recovery. Patients should also be motivated to improve and return to work, and meet the patient selection criteria outlined below. Criteria for the general use of multidisciplinary pain management programs: Outpatient pain rehabilitation programs may be considered medically necessary when all of the following criteria are met: (1) An adequate and thorough evaluation has been made, including baseline functional testing so follow-up with the same test can note functional improvement; (2) Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement; (3) The patient has a significant loss of ability to function independently resulting from the chronic pain; (4) The patient is not a candidate where surgery or other treatments would clearly be warranted controversial or optional surgery,(if a goal of treatment is to prevent or avoid controversial or optional surgery, a trial of 10 visits may be implemented to assess whether surgery may be avoided); (5) The patient exhibits motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change; & (6) Negative predictors of success above have been addressed. Functional restoration

programs are recommended, although research is still ongoing as to how to most appropriately screen for inclusion in these programs. Based on the information presented the patient appears to be a candidate for physical/aquatic therapy, to further improve her overall conditioning and subsequent transition to self-directed independent rehabilitation program. The medical records do not support that an FRP is clinically indicated in this case, as several of the required criteria have not been met. For example, she is continuing several conservative therapies, and she has benefitted, as so other methods of treating chronic pain have been successful and there is existence of other options likely to result in significant clinical improvement, also she does not present with significant loss of ability to function independently resulting from the chronic pain. Given all of these factors, this patient is not considered a candidate for a FRP, and therefore assessment for placement in such a program is not clinically indicated. The request for functional capacity program is not medically necessary. The request is non-certified.