

<b>Case Number:</b>	CM15-0005300		
<b>Date Assigned:</b>	01/16/2015	<b>Date of Injury:</b>	09/05/2014
<b>Decision Date:</b>	03/26/2015	<b>UR Denial Date:</b>	12/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/09/2015

### 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: Pennsylvania  
 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:

This 54-year-old female worker sustained injuries to her back, right foot and ankle and the wrists and hands due to cumulative trauma; the date of injury is 9/5/14. The PR2 dated 10/22/14 states she was diagnosed with anxiety state, unspecified, lumbosacral sprain/strain and other tenosynovitis of the hands and wrists. Treatments have included chiropractic treatments, medications, trigger point injections, wrist braces, and use of an ergonomic keyboard. She received evaluation by a psychologist with psychological testing on 11/24/14, with diagnoses of major depressive disorder, generalized anxiety disorder with panic attacks, and psychological factors affecting medical condition. The psychologist documented stress-intensified medical symptoms including chest pain, shortness of breath, constipation, and high blood pressure. Cognitive behavioral therapy and biofeedback as well as medication management sessions were recommended by the evaluating psychologist. She was also seen by a psychiatrist who prescribed Lexapro, but the PR2 of 10/22/14 notes that the injured worker had not yet filled the prescription for Lexapro. She has attended stress classes. The injured worker reported intermittent pain in the bilateral forearms, wrists, and hands, as well as headaches. Examination showed elevated blood pressure, tenderness to palpation of the thoracic and lumbar spine without decrease in strength or sensory deficit, and negative Tinel's and Phalen's signs. On 11/10/14, a treating orthopedist noted complaints of intermittent pain in the cervical spine with numbness and tingling radiating to the arms, bilateral hand pain with numbness and tingling, headaches, lumbar spine pain with tingling, constipation, anxiety, depression, and stress. Difficulty with multiple activities of daily living were noted. Examination showed cervical spine stiffness, wrist joint pain to palpation,

positive Tinel's and Phalens signs bilaterally, decreased sensation of the thumb/index/long finger bilaterally, spasm at L3-S1, normal lower extremity strength and deep tendon reflexes, and decreased lower extremity sensation. X-ray of the cervical spine showed multilevel degenerative changes with some disc space narrowing; x-ray of the lumbar spine showed L5-S1 disc collapse. The treating orthopedist documented diagnoses of cervical spine sprain and strain, bilateral upper extremity tenosynovitis and overuse syndrome with exam consistent with carpal tunnel, bilateral shoulder impingement, lumbar spine disc collapse at L5-S1 with numbness of the right foot, and non-orthopedic concerns including chronic headaches, gastrointestinal (GI) upset, stress, anxiety, difficulty sleeping, and memory loss. It was noted that the injured worker would be referred for consultation for the non-orthopedic concerns. It was noted that the injured worker may return to work with restrictions. The treating provider requests cervical and lumbar spine MRIs without contrast, electromyogram/nerve conduction velocity (EMG/NCV) of the bilateral lower extremities, Terocin lotion and psychology and internal medicine consults. The Utilization Review on 12/11/14 non-certified cervical and lumbar spine MRIs without contrast, EMG/NCV of the bilateral lower extremities, Terocin lotion and psychology and internal medicine consults, citing CA MTUS, ACOEM, and ODG guidelines.

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

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

#### **MRI of the cervical spine without contrast: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): p. 170-172, 177-179, 182.

**Decision rationale:** Per the MTUS/ACOEM, for most patients presenting with neck problems, special studies are not needed unless a 3-4 week period of conservative care and observation fails to improve symptoms. Criteria for ordering imaging studies include emergence of a red flag, or physiologic evidence of tissue insult or neurologic dysfunction, and prior to an invasive procedure. Physiologic evidence may be in the form of neurologic findings on physical examination and electrodiagnostic studies. In this case, there were no red flag signs or symptoms, physiologic evidence of tissue insult or neurologic dysfunction related to the cervical spine, or plans for an invasive procedure. No electrodiagnostic studies have yet been performed. The treating physician documented an impression of cervical spine sprain and strain, and carpal tunnel syndrome. There was no evidence of radiculopathy related to the cervical spine. Due to lack of indication, the request for MRI of the cervical spine is not medically necessary.

#### **MRI of the lumbar spine without contrast: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints  
Page(s): p. 303-305, 309.

**Decision rationale:** The ACOEM guidelines state that unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient to warrant imaging in patients who do not respond to treatment and who would consider surgery as an option. When the neurologic examination is less clear, further physiologic evidence of nerve dysfunction, such as electromyography, should be obtained before ordering an imaging study. Imaging studies should be reserved for cases in which surgery is considered or red-flag diagnoses are being evaluated. Magnetic resonance imaging (MRI) is the test of choice for patients with prior back surgery. Computed tomography or MRI are recommended when cauda equina, tumor, infection, or fracture are strongly suspected and plain film radiographs are negative. In this case, no red flag diagnoses were documented, there was no history of prior back surgery, and the physical examination findings did not document evidence of specific nerve root compromise, as there was no dermatomal sensory loss or evidence of decreased strength or reflexes in the lower extremities. No electrodiagnostic studies were documented. No surgery was planned. For these reasons, the request for MRI of the lumbar spine is not medically necessary.

**EMG/NCV of the bilateral lower extremities:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints  
Page(s): p. 303-304. Decision based on Non-MTUS Citation low back chapter: EMGs (electromyography), nerve conduction studies

**Decision rationale:** This injured worker had low back pain, with documentation of nonspecific decreased lower extremity sensation. The ACOEM states that electromyography (EMG) may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. The ODG states that EMG may be useful to obtain unequivocal evidence of radiculopathy after one month of conservative therapy, but that EMGs are not necessary if radiculopathy is already clinically obvious. The guidelines do not recommend nerve conduction velocity (NCV) for evaluation for radiculopathy in the low back. The ODG states that there is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. As the NCV is not recommended, the request for EMG/NCV is not medically necessary.

**Terocin lotion:** 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 topical analgesics p. 111-113 medications for chronic pain, p. 60 salicylate topicals p. 104 Pa. Decision

based on Non-MTUS Citation Uptodate: camphor and menthol: drug information. In UpToDate, edited by Ted. W. Post, published by UpToDate in Waltham, MA, 2015.

**Decision rationale:** Per the MTUS, topical analgesics are recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The treating physician has not discussed the ingredients of Terocin and the specific indications for this injured worker. Per the manufacturer, Terocin contains Methyl Salicylate 25%, Menthol 10%, Capsaicin 0.025%, and Lidocaine 2.5%. Per page 60 of the MTUS, medications should be trialed one at a time. Regardless of any specific medication indications for this patient, the MTUS recommends against starting multiple medications simultaneously. Per the MTUS, any compounded product that contains at least one drug that is not recommended, is not recommended. Topical salicylates are recommended for use for chronic pain and have been found to be significantly better than placebo in chronic pain. Topical lidocaine in the form of the Lidoderm patch is indicated for neuropathic pain. The MTUS does not recommend topical lidocaine other than Lidoderm patch for neuropathic pain. Capsaicin is recommended as an option in patients who have not responded or are intolerant to other treatments. Capsaicin alone in the standard formulation readily available OTC may be indicated for some patients. The indication in this case is unknown, as the patient has not failed adequate trials of other treatments. The MTUS and ODG are silent with regard to menthol. It may be used for relief of dry, itchy skin. This agent carries warnings that it may cause serious burns. The site of applications and directions for use were not described for this compounded product. As it contains a form of topical lidocaine which is not recommended, the compound itself is not recommended. There was no documentation of trial and failure of antidepressants and anticonvulsants. For these reasons, the request for Terocin lotion is not medically necessary.

**Psychology consultation:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 398.

**Decision rationale:** The ACOEM states that specialty referral may be necessary when patients have significant psychopathology or serious medical comorbidities. The ACOEM notes that patients with serious conditions such as severe depression should be referred to a specialist. This injured worker has undergone a recent psychological evaluation including psychological testing on 11/24/14, with resultant diagnoses of major depressive disorder, generalized anxiety disorder with panic attacks, and psychological factors affecting medical condition. Cognitive behavioral therapy and biofeedback as well as medication management sessions were recommended by the evaluating psychologist. As the injured worker has already undergone a recent psychology consultation with findings and recommendations as noted, another psychology consultation would be unnecessary and redundant. For this reason, the request for psychology consultation is not medically necessary.

**Internal medicine consultation:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): p. 398. Decision based on Non-MTUS Citation low back chapter: office visits

**Decision rationale:** The treating orthopedist documented multiple non-orthopedic concerns including chronic headaches, gastrointestinal (GI) upset, stress, anxiety, difficulty sleeping, and memory loss. The psychologist documented stress-intensified medical symptoms including chest pain, shortness of breath, constipation, and high blood pressure. Blood pressure was elevated at the October 2014 office visit with the primary treating provider. The ODG notes that office visits are recommended as determined to be medically necessary. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The ACOEM states that specialty referral may be necessary when patients have significant psychopathology or serious medical comorbidities and that all new medical conditions or exacerbations of chronic medical conditions should be evaluated and treated according to the best clinical practices. Due to the symptoms as described as documented by two treating providers, the request for internal medicine consultation is medically necessary.