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| <b>Case Number:</b>   | CM15-0013754 |                              |            |
| <b>Date Assigned:</b> | 02/02/2015   | <b>Date of Injury:</b>       | 08/06/2014 |
| <b>Decision Date:</b> | 03/26/2015   | <b>UR Denial Date:</b>       | 12/19/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 01/23/2015 |

### 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: Texas, Ohio, California  
 Certification(s)/Specialty: Preventive Medicine, Occupational 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 applicant is a represented 44-year-old [REDACTED] beneficiary who has filed a claim for neck and shoulder pain reportedly sustained on August 6, 2014. In a Utilization Review Report dated December 19, 2014, the claims administrator partially approved a request for 12 sessions of chiropractic manipulative therapy as six sessions of the same, partially approved a request for Flexeril, approved a request for Naprosyn, denied a request for Prilosec, denied a request for urine drug screen, denied cervical MRI imaging, denied shoulder MRI imaging, and denied a multimodality transcutaneous electrotherapy device, and denied a hot and cold wrap. The claims administrator referenced a November 24, 2014 progress note in its determination. The applicant's attorney subsequently appealed. In an RFA form of January 5, 2015, twelve sessions of chiropractic manipulative therapy and myofascial release therapy were sought, along with a spine surgery consultation. In an associated progress note of the same date, January 5, 2015, the applicant reported ongoing complaints of neck and shoulder pain, 7/10. The attending provider referenced a shoulder MRI of December 23, 2014 notable for tendinosis, arthritis, and bursitis. 5/5 upper extremity strength was noted. Hyposensorium was noted about the right upper extremity. The attending provider also alluded to cervical MRI imaging of December 23, 2014 notable for multilevel disk protrusions, most prominent at the C3-C4 level, generating some indentation upon the spinal cord and at C5-C6, causing spinal stenosis and effacement of the exiting C6 nerve root. Additional chiropractic manipulative therapy, electrodiagnostic testing of the bilateral upper extremities, a spine surgery consultation, a TENS-interferential unit device, a hot and cold wrap, Naprosyn, Prilosec, Flexeril, and

Neurontin were endorsed while the applicant was placed off of work, on total temporary disability, for an additional six weeks. It was acknowledged that the request for chiropractic manipulative therapy represented a request for extension of previously received chiropractic manipulative therapy. There was no mention of any issues with reflux, heartburn, and/or dyspepsia on the January 5, 2015 progress note at issue.

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

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

**Prilosec 20 MG #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk page Chronic Pain Medical Treatment Guidelines 8 C.C.R.

**Decision rationale:** 1. No, the request for Prilosec, a proton pump inhibitor, was not medically necessary, medically appropriate, or indicated here. While page 69 of the MTUS Chronic Pain Medical Treatment Guidelines does acknowledge that proton pump inhibitors such as Prilosec are indicated to combat issues with NSAID-induced dyspepsia, in this case, however, there was no mention of the applicant's having issues with reflux, heartburn, and/or dyspepsia, either NSAID-induced or stand-alone, on the January 5, 2015 progress note at issue. Therefore, the request was not medically necessary.

**UDS:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Drug testing, Chronic Pain Medical Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effecti. Decision based on Non-MTUS Citation Chronic Pain

**Decision rationale:** 2. Similarly, the request for a urine drug screen was likewise not medically necessary, medically appropriate, or indicated here. While page 43 of the MTUS Chronic Pain Medical Treatment Guidelines does support intermittent drug testing in the chronic pain context, the MTUS does not establish specific parameters for or identify a frequency with which to perform drug testing. ODGs Chronic Pain Chapter Urine Drug Testing topic, however, stipulates that an attending provider attach an applicant's complete medication list to the request for authorization for testing, eschew confirmatory and/or quantitative testing outside of the Emergency Department Drug Overdose context, clearly state which drug tests and/or drug panels he intends to test for, attempt to conform to the best practices of the United States Department of Transportation (DOT) when performing drug testing, and attempt to categorize the applicants into higher- or lower-risk categories for which more or less frequent drug testing would be indicated. Here, however, the attending provider did not identify when the applicant was last

tested. It was not clearly stated which drug tests and/or drug panels he intends to test for. The attending provider did not clearly delineate the applicant's complete medication list. It was not stated when the applicant was last tested. It was not stated whether the applicant was a higher- or lower-risk individual for which more or less frequent drug testing would be indicated. Therefore, the request was not medically necessary.

**MRI of The Cervical Spine: Overturned**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 182.

**Decision rationale:** 3. The request for cervical MRI imaging, conversely, was medically necessary, medically appropriate, and indicated here. As noted in the MTUS Guideline in ACOEM Chapter 8, Table 8-8, page 182, MRI or CT imaging is recommended to validate a diagnosis of nerve root compromise, based on clear history and physical exam findings, in preparation for an invasive procedure. Here, the attending provider did seemingly act upon the results of previously ordered cervical MRI imaging. The attending provider did propose a spine surgery consultation in response to the applicant's ongoing radicular pain complaints and multilevel cervical disk herniations, some of which generated nerve root effacement. Therefore, the cervical MRI was medically necessary.

**MRI of The Right Shoulder: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 214.

**Decision rationale:** 4. Conversely, the MRI of the right shoulder was not medically necessary, medically appropriate, or indicated here. As noted in the MTUS Guideline in ACOEM Chapter 9, Table 9-6, page 214, the routine usage of MRI imaging of the shoulder without surgical indications is deemed not recommended. Here, the attending provider did not act on the results of the proposed shoulder MRI. The applicant's primary treating provider did not go on to pursue a shoulder surgery consultation based on the outcome of the same. The applicant's shoulder MRI was, furthermore, essentially negative, and failed to uncover any evidence of a lesion amenable to surgical correction. Therefore, the request was not medically necessary.

**TENS/Multi-Stim Unit/IF Unit, Body Part Unknown: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of TENS: page Chronic Pain Medical Treatment Guidelines 8 C.C.R. 9792.20 -.

**Decision rationale:** 5. Similarly, the request for TENS/multi-stimulator unit/interferential unit was not medically necessary, medically appropriate, or indicated here. As noted on page 116 of the MTUS Chronic Pain Medical Treatment Guidelines, a purchase of a TENS unit should be predicated on evidence of successful outcome during an earlier one-month trial, in terms of both pain relief and function. Similarly, page 120 of the MTUS Chronic Pain Medical Treatment Guidelines also notes that purchase of an interferential unit should be reserved for applicants who demonstrate a favorable outcome during an earlier one-month trial of the same, in terms of increased functional improvement, less reported pain, and medication reduction. Here, as noted previously, the attending provider sought authorization for the combination TENS-IF device without previously proposing a one-month trial of the same. Therefore, the request was not medically necessary.

**Hot and Cold Pack/Wrap or Thermo Combo Unit:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174. Decision based on Non-MTUS Citation ACOEM V.3 > Cervical and Thoracic Spine > Allied Health Interventions > Cryotherapies Recommendation: Routine Use of Cryotherapies in Health Care Provider Offices or Home Use of High-tech Devices Routine use of cryotherapies in health care provider offices or home use of a high-tech device for the treatment of cervicothoracic pain is not recommended. However, single use of low-tech cryotherapy (ice in a plastic bag) for severe exacerbations is reasonable. Strength of Evidence Not Recommended, Insufficient Evidence (I)

**Decision rationale:** 6. The proposed hot and cold pack-wrap/thermal combination unit was likewise not medically necessary, medically appropriate, or indicated here. The applicant's primary pain generator here is the neck. While the MTUS Guideline in ACOEM Chapter 8, Table 8-5, page 174 does recommend at-home local applications of heat and cold as methods of symptom control for neck pain complaints, by implication, however, ACOEM does not endorse more elaborate devices for delivering cryotherapy and heat therapy, as was proposed here. The Third Edition ACOEM Guidelines Cervical and Thoracic Spine Chapter takes a stronger position against usage of high-tech devices for delivering cryotherapy, explicitly stating that such devices are not recommended. Here, the attending provider did not furnish any compelling applicant-specific rationale or medical evidence so as to offset the unfavorable ACOEM positions on the article at issue. Therefore, the request was not medically necessary.

**Chiropractic Treatment with Chiropractic Supervised Physiotherapy 2 Times A Week for 6 Weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulations.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation page Chronic Pain Medical Treatment Guidelines 8 C.C.R. 9792.20 -.

**Decision rationale:** 6. The proposed hot and cold pack-wrap/thermal combination unit was likewise not medically necessary, medically appropriate, or indicated here. The applicant's primary pain generator here is the neck. While the MTUS Guideline in ACOEM Chapter 8, Table 8-5, page 174 does recommend at-home local applications of heat and cold as methods of symptom control for neck pain complaints, by implication, however, ACOEM does not endorse more elaborate devices for delivering cryotherapy and heat therapy, as was proposed here. The Third Edition ACOEM Guidelines Cervical and Thoracic Spine Chapter takes a stronger position against usage of high-tech devices for delivering cryotherapy, explicitly stating that such devices are not recommended. Here, the attending provider did not furnish any compelling applicant-specific rationale or medical evidence so as to offset the unfavorable ACOEM positions on the article at issue. Therefore, the request was not medically necessary.

**Flexeril 7.5 MG #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine (Flexeril) page Chronic Pain Medical Treatment Guidelines 8 C.C.R. 9792.20 - 9.

**Decision rationale:** 8. Finally, the request for Flexeril (cyclobenzaprine) was likewise not medically necessary, medically appropriate, or indicated here. As noted on page 41 of the MTUS Chronic Pain Medical Treatment Guidelines, addition of cyclobenzaprine or Flexeril to other agents is not recommended. Here, the applicant was reportedly using a variety of other agents, including Neurontin, Naprosyn, etc. Adding cyclobenzaprine or Flexeril to the mix was not recommended. It is further noted that the 60-tablet supply of cyclobenzaprine at issue represents treatment well in excess of the short course of therapy for which cyclobenzaprine (Flexeril) is recommended, per page 41 of the MTUS Chronic Pain Medical Treatment Guidelines. Therefore, the request was not medically necessary.