MAXIMUS Federal Services

Case Number:	CM15-0112856		
Date Assigned:	06/24/2015	Date of Injury:	06/07/2014
Decision Date:	10/16/2015	UR Denial Date:	05/13/2015
Priority:	Standard	Application Received:	06/11/2015

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: California
Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 42 year old female, who sustained an industrial injury on June 7, 2014. The injured worker reported a slip and fall causing shoulder, knee, elbow and back pain. The injured worker was diagnosed as having bilateral shoulder impingement, lumbago and lumbar radiculitis/neuritis. Treatment to date has included x-rays, physical therapy and magnetic resonance imaging (MRI). A progress note dated April 21, 2015 provides the injured worker complains of shoulder, elbow and low back pain. She reports shoulder pain rated 9/10 in the right and 7/10 in the left with instability, clicking, popping and grinding sensation. Her elbow pain is 8/10 on the right and 6/10 on the left with swelling, numbness, tingling, weakness, clicking and popping. The low back pain is rated 9/10 with numbness, tingling, weakness and burning. Physical exam notes shoulder tenderness with impingement and decreased range of motion (ROM). The elbows have decreased range of motion (ROM). The lumbar spine is tender on palpation with positive straight leg raise on the left and decreased range of motion (ROM). The plan includes muscle stimulator, heat/cold, home exercise program (HEP), electromyogram, nerve conduction study, magnetic resonance imaging (MRI), orthopedic, pain management and functional capacity evaluation, acupuncture and topical and oral medication.

IMR ISSUES, DECISIONS AND RATIONALES

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

Muscle stimulator unit x 5 months: 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): Transcutaneous electrotherapy.

Decision rationale: Regarding the request for muscle stimulator unit, Chronic Pain Medical Treatment Guidelines state that transcutaneous electrical nerve stimulation (TENS) is not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option if used as an adjunct to a program of evidence-based functional restoration. Guidelines recommend failure of other appropriate pain modalities including medications prior to a TENS unit trial. Prior to TENS unit purchase, one month trial should be documented as an adjunct to ongoing treatment modalities within a functional restoration approach, with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function. Within the documentation available for review, there is no indication that the patient has undergone a TENS unit trial, and no documentation of any specific objective functional deficits which a tens unit trial would be intended to address. Additionally, it is unclear what other treatment modalities are currently being used within a functional restoration approach. In the absence of clarity regarding those issues, the currently requested muscle stimulator unit is not medically necessary.

Heat/cold pack: Overturned

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

MAXIMUS guideline: Decision based on MTUS Shoulder Complaints 2004, Section(s): Initial Care. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Cold packs and Heat therapy.

Decision rationale: The ACOEM, Shoulder Complaints Chapter, state the following: "Patients" at-home applications of heat or cold packs may be used before or after exercises and are as effective as those performed by a therapist. Initial use of less-invasive techniques provides an opportunity for the clinician to monitor progress before referral to a specialist." Therefore, given this patient has ongoing pain in the shoulder and knee region. The application of heat and cold packs are reasonable and is medically necessary.

Home exercise kit for lumbar 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.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Exercise.

Decision rationale: Regarding the request for home exercise kit, the CPMTG does not have specific provision for exercise kits. Guidelines do not support the need for additional exercise equipment, unless there is documentation of failure of an independent exercise program without equipment, despite physician oversight and modification. Within the documentation available for review, there is no indication that the patient has failed an independent program of home exercise without kit. In the absence of such documentation, the currently requested home exercise kit is not medically necessary.

EMG/NCV of lower 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, Low Back.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Electrodiagnostic Studies.

Decision rationale: Regarding the request for NCV of the lower extremities, ACOEM Practice Guidelines state that unequivocal objective findings that identify specific nerve compromise on the neurologic exam are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery. When a neurologic examination is less clear however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. The guidelines further specify that electromyography may be useful to identify subtle focal neurologic dysfunction in patients with low back symptoms lasting more than 3 to 4 weeks. Within the documentation available for review, there is lack of a full neurologic examination documenting abnormalities in the sensory, motor, or deep tendon reflex systems to support a diagnosis of specific nerve compromise. Additionally, if such findings are present but have not been documented, there is no documentation that the patient has failed conservative treatment directed towards these complaints. Given this, the current request is not medically necessary.

MRI of bilateral shoulders (2): 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 Shoulder Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter, Magnetic resonance imaging (MRI).

Decision rationale: Regarding the request for MRI of the shoulder, ACOEM Guidelines state that more specialized imaging studies are not recommended during the 4 to 6 weeks of activity limitation due to shoulder symptoms except when a red flag is noted on history or examination. Cases of impingement syndrome are managed the same whether or not radiographs show calcium in the rotator cuff or degenerative changes are seen in or around the glenohumeral joint or AC joint. Guidelines further specify imaging studies for physiologic evidence of tissue insult

or neurovascular dysfunction, failure to progress in a strengthening program intended to avoid surgery, and clarification of the anatomy prior to an invasive procedure. ODG recommends MRI of the shoulder for subacute shoulder pain with suspicion of instability/labral tear or following acute shoulder trauma with suspicion of rotator cuff tear/impingement with normal plain film radiographs. Within the documentation available for review, it does not appear the patient has failed conservative treatment options. Furthermore, it is unclear how an MRI will change the patient's current treatment plan. In addition, there are no red flag symptoms or exam finding to warrant the need for MRI imagine at this time. Given this, the currently requested bilateral shoulder MRI is not medically necessary.

MRI of the lumbar 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, Minnesota Rules.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, MRI Topic.

Decision rationale: Regarding the request for repeat lumbar MRI, ACOEM Practice Guidelines do not have specific guidelines on when a repeat study is warranted. In general, lumbar MRI is recommended when there are unequivocal objective findings that identify specific nerve compromise on the neurologic examination in patients who do not respond to treatment and would consider surgery an option. The Official Disability Guidelines state that repeat MRIs should be reserved for cases in which a significant change in pathology has occurred. Within the documentation available for review, there is no identification of any objective findings that identify specific nerve compromise on the neurologic exam. Furthermore, there is no documentation indicating how the patient's subjective complaints and objective findings have changed since the time of the most recent MRI of the lumbar spine. In the absence of clarity regarding those issues, the currently requested repeat lumbar MRI is not medically necessary.

Ortho evaluation for shoulders: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 7: Independent Medical Examinations and Consultations, page 127.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Occupational Medicine Practice Guidelines, Independent Medical Examinations and Consultations Chapter, page 127.

Decision rationale: In regards to the request for orthopedic consultation, the ACOEM Practice Guidelines recommend expert consultation when "when the plan or course of care may benefit from additional expertise." Thus, the guidelines are relatively permissive in allowing a requesting provider to refer to specialists. Within the submitted documentation, it is apparent that

the worker continues with significant pain in multiple body regions, including bilateral shoulders. The patient has failed conservative therapies including pain medications and PT. Given the chronicity of this pain, it is reasonable to seek an orthopedic consultation that can provide additional insight and options for this worker. The request is medically necessary.

Pain management evaluation for lumbar spine: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 7: Independent Medical Examinations and Consultations, page 127.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, Independent Medical Examinations and Consultations Chapter, page 127, Other Medical Treatment Guideline or Medical Evidence: State of Colorado, Chronic Pain Disorder Medical Treatment Guidelines, Exhibit Page Number 52.

Decision rationale: State of Colorado, Chronic Pain Disorder Medical Treatment Guidelines, Exhibit Page Number 52 Consultation or referral to a pain specialist should be considered when the pain persists but the underlying tissue pathology is minimal or absent and correlation between the original injury and the severity of impairment is not clear. Consider consultation if suffering and pain behaviors are present and the patient continues to request medication, or when standard treatment measures have not been successful or are not indicated. Within the submitted documentation, it is apparent that the worker continues with significant pain in multiple body regions, including bilateral shoulders, left elbow, and lower back region. The patient has failed conservative therapies including pain medications, and physical therapy without improvement. Given the chronicity of this pain, it is reasonable to seek a pain consultation that can provide additional insight and options for this worker. Therefore, the request is medically necessary.

Cyclobenzaprine HCL 7.5mg #30: 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): Muscle relaxants (for pain).

Decision rationale: Regarding the request for cyclobenzaprine, Chronic Pain Medical Treatment Guidelines support the use of nonsedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Guidelines go on to state that cyclobenzaprine specifically is recommended for a short course of therapy. Within the documentation available for review, there is no identification of a specific analgesic benefit or objective functional improvement as a result of the cyclobenzaprine. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. Given this, the current request is not medically necessary.

Tramadol 50mg #90: 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): Opioids, California Controlled Substance Utilization Review and Evaluation System (CURES) [DWC], Opioids, criteria for use, Opioids for chronic pain, Opioids, specific drug list.

Decision rationale: Regarding the request for Tramadol, Chronic Pain Medical Treatment Guidelines state that Ultram is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no indication that the medication is improving the patient's pain or function, as the patient continue to have worsening shoulder and back pain. As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested Tramadol is not medically necessary.

Compound: Gabapentin 10%, Amitriptyline 10%, Bupivacaine 5% in cream base 180 grams: 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: With regard to this request for a topical compounded cream that contains gabapentin as a component, the CPMTG does not recommend topical gabapentin. On page 113 of the Chronic Pain Medical Treatment Guidelines, the following is stated: "Gabapentin: Not recommended. There is no peer-reviewed literature to support use." The guidelines further state that if one drug or drug class of a compounded formulation is not recommended, then the entire compounded formulation is not recommended. Therefore, the topical gabapentin component is not recommended, and the entire formulation is not medically necessary.

Compound: Flurbiprofen 20%, Baclofen 5%, Dexamethasone 2%, Menthol 2%, Camphor 2%, Capsaicin 0.025% in cream base 180 grams: 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: Regarding this request, one of the components requested is topical baclofen. Chronic Pain Medical Treatment Guidelines 8 C.C.R. 9792.20 -9792.26 MTUS (Effective July 18, 2009), page 113 of 127 state the following: "Topical Baclofen: Not recommended. There is currently one Phase III study of Baclofen-Amitriptyline- Ketamine gel in cancer patients for treatment of chemotherapy-induced peripheral neuropathy. There is no peer-reviewed literature to support the use of topical baclofen." Given these guidelines, the topical baclofen is not medically necessary. Since any formulation must have all components as recommended in order for the formulation to be medically necessary, this request is not medically necessary.

Functional capacity evaluation for bilateral shoulders and lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Functional improvement measures. Decision based on Non-MTUS Citation Official Disability Guidelines, Fitness for Duty Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness for Duty Chapter, Functional Capacity Evaluation and Other Medical Treatment Guidelines ACOEM, Chapter 7, p. 137-138.

Decision rationale: Regarding request for functional capacity evaluation, ACOEM Practice Guidelines state that there is not good evidence that functional capacity evaluations are correlated with a lower frequency of health complaints or injuries. ODG states that functional capacity evaluations are recommended prior to admission to a work hardening program. The criteria for the use of a functional capacity evaluation includes case management being hampered by complex issues such as prior unsuccessful return to work attempts, conflicting medical reporting on precautions and/or fitness for modified job, or injuries that require detailed explanation of a worker's abilities. Additionally, guidelines recommend that the patient be close to or at maximum medical improvement with all key medical reports secured and additional/secondary conditions clarified. Within the documentation available for review, there is no indication that there has been prior unsuccessful return to work attempts, conflicting medical reporting, or injuries that would require detailed exploration. Given this, the currently requested functional capacity evaluation is not medically necessary.

Acupuncture 2 x 6 for the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment 2007.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment 2007.

Decision rationale: Regarding the request for acupuncture, California MTUS does support the use of acupuncture for chronic pain. Acupuncture is recommended to be used as an adjunct to

physical rehabilitation and/or surgical intervention to hasten functional recovery. Additional use is supported when there is functional improvement documented, which is defined as either a clinically significant improvement in activities of daily living or a reduction in work restrictions and a reduction in the dependency on continued medical treatment. A trial of up to 6 sessions is recommended, with up to 24 total sessions supported when there is ongoing evidence of functional improvement. In the case of this particular request (for 12 sessions), the number of requested sessions of acupuncture is in excess of that recommended by guidelines cited above. The guidelines specifically state that the time to produce functional improvement is within six treatments. The independent medical review process cannot modify requests. Therefore, this request is not medically necessary.

Acupuncture 2 x 6 to the shoulders: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment 2007.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment 2007.

Decision rationale: Regarding the request for acupuncture, California MTUS does support the use of acupuncture for chronic pain. Acupuncture is recommended to be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Additional use is supported when there is functional improvement documented, which is defined as either a clinically significant improvement in activities of daily living or a reduction in work restrictions and a reduction in the dependency on continued medical treatment. A trial of up to 6 sessions is recommended, with up to 24 total sessions supported when there is ongoing evidence of functional improvement. In the case of this particular request (for 12 sessions), the number of requested sessions of acupuncture is in excess of that recommended by guidelines cited above. The guidelines specifically state that the time to produce functional improvement is within six treatments. The independent medical review process cannot modify requests. Therefore, this request is not medically necessary.