

Case Number:	CM15-0117137		
Date Assigned:	06/25/2015	Date of Injury:	08/02/2010
Decision Date:	08/19/2015	UR Denial Date:	06/10/2015
Priority:	Standard	Application Received:	06/17/2015

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: Arizona, Michigan

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 injured worker is a 65 year old female, who sustained an industrial injury on 08/02/2010. According to a progress report dated 04/29/2015 the injured worker reported constant aching pain, that radiated into her bilateral upper extremities. She also report numbness in her bilateral hands and all digits overnight. Looking over her shoulder, up and down increased her pain. Sudden movement also increased her pain. She also reported low back pain. Physical examination demonstrated normal cervical lordosis and post-surgical scar over the left knee. Hoffman's, Babinski, Stransk's, straight leg raise, Bowstring sign, cross leg raise, Spurling's test and Lhermitte's sign were negative. Dermatomes C2-S2 was intact to light touch and pinprick. Strength was 5/5 with free range of motion in all major joints. Myotomes C5-S2 right and left in upper and lower extremities had no structural deformities. Gait pattern was normal. Hypertonicity was noted in the paraspinals L3-S1 bilaterally and bilateral trapezii. Paraspinals L3-S1 bilaterally and trapezii bilaterally was tender to palpation. Cervical, thoracic and lumbar structure range of motion was intact and symmetric except was mildly limited with lumbar extension. There was limited cervical extension bilaterally. Facet loading was positive in the lumbar and cervical bilaterally. Faber's, Gaenslen's and sacroiliac thigh thrust test was negative. CM#-Ketoprofen cream 20% was prescribed for use over the paraspinals to limit need for oral medications and their side effects. Cervical MRI was order to evaluate radicular complaints. The treatment plan also included a follow up in 8 weeks, trigger point injection bilaterally for the trapezius x 2 each and a home exercise plan for cervical and lumbar stabilization. According to a progress report dated 05/19/2015, chief complaints included right upper extremity, left lower

extremity and low back pain. The date of injury was noted as 11/01/1977 - 11/05/2008. She reported that her injury occurred while working as a cook when she tripped on a floor mat and fell forward onto her face and left knee. She had immediate neck and back pain. Treatment to date has included 24 sessions of acupuncture, 24 sessions of chiropractic treatment, rhizotomy bilateral L4-5 on 04/09/2015, medial branch block L4-5 and rhizotomy L4-5. She was being seen by pain management but stopped due to being allergic to "all pain medications". She underwent left knee surgery on 04/22/2015 and had completed 6 sessions of post-operative physical therapy. She reported increased soreness in her low back since starting therapy for her knee. She reported constant aching pain in her neck and occasional numbness at night in her bilateral upper extremities. Neck pain was rated 5 on a scale of 1-10. She reported constant stabbing pain that will go into her sacrum and aching pain that went from her low back into her left hip. She was unable to stand or walk for long periods of time. Low back pain was rated 5-6 on a scale of 1-10. Current medications included LidoPro Topical Ointment. She reported good relief for a few hours with its use. MRI of the cervical and lumbar spine was noted dating back to 05/01/2012. Physical examination demonstrated normal cervical lordosis and post-surgical scar over the left knee. Hoffman's, Babinski, Strask's, straight leg raise, Bowstring sign, cross leg raise, Spurling's test and Lhermitte's sign were negative. Dermatomes C2-S2 was intact to light touch and pinprick. Strength was 5/5 with free range of motion in all major joints. Myotomes C5-S2 right and left in upper and lower extremities had no structural deformities. Gait pattern was normal. Hypertonicity was noted in the paraspinals L3-S1 bilaterally. Paraspinals L3-S1 bilaterally was tender to palpation. Cervical, thoracic and lumbar structure range of motion was intact and symmetric except was mildly limited with lumbar extension. Facet loading was positive bilaterally. Faber's, Gaenslen's and sacroilia c thigh thrust test was negative. Assessment included lumbar facet arthropathy, lumbar myofascial strain and lumbar degenerative disc disease. The treatment plan included continuance of Ketoprofen cream for use over paraspinals, continuance of home exercise program for lumbar stabilization, follow up in 6 weeks, MRI of the cervical spine and request for trigger point injections bilaterally for the trapezius x 2 each. Currently under review is the request for MRI of the cervical spine, bilateral trigger point injections to the trapezius x 2, CM3-Ketoprofen cream 20%, and a follow-up appointment.

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: 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), neck and upper back, MRI.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177, 178.

Decision rationale: CA MTUS ACOEM guidelines state that the criteria for ordering imaging studies include emergence of a red flag, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery and clarification of the anatomy prior to an invasive procedure. Documentation failed to show that criteria were met. As such, the request for MRI of the cervical spine is not medically necessary.

Bilateral trigger point injections to the Trapezius x 2: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 341, Chronic Pain Treatment Guidelines criteria for the trigger point injections.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger Point Injections Page(s): 122.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines state trigger point injections with a local anesthetic may be recommended for the treatment of chronic low back or neck pain with myofascial pain syndrome when all of the following criteria are met: (1) Documentation of circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain; (2) Symptoms have persisted for more than three months; (3) Medical management therapies such as ongoing stretching exercises, physical therapy, NSAIDs and muscle relaxants have failed to control pain; (4) Radiculopathy is not present (by exam, imaging or neuro -testing); (5) Not more than 3-4 injections per session; (6) No repeat injections unless a greater than 50% pain relief is obtained for six weeks after an injection and there is documented evidence of functional improvement; (7) Frequency should not be at an interval less than two months; (8) Trigger point injection with any substance (e.g., saline or glucose) other than local anesthetic with or without steroid are not recommended. Documentation failed to meet criteria, as there was no documentation of circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain. Documentation also states that the injured worker had not tried physical therapy. Therefore, the request for bilateral trigger point injections to the trapezius x 2 is not medically necessary.

CM3-Ketoprofen cream 20%: 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, 112.

Decision rationale: Per the MTUS Chronic Pain Medical Treatment Guidelines, topical analgesics are recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. In this case, there was no documentation of trial and failure of antidepressants or anticonvulsants. Ketoprofen is a NSAID (non-steroidal anti-inflammatory drug). The only FDA-approved topical NSAIDs are diclofenac formulations. Guidelines state that Ketoprofen is not currently FDA approved for a topical application. It has an extremely high incidence of photo contact dermatitis. Absorption of the drug depends on the base that it is delivered in. Topical treatment can result in blood concentration and systemic effect comparable to those from oral forms, and caution should be used for patients at risk, including those with renal failure. As such the request for CM3-Ketoprofen cream 20% is not medically necessary.

Follow-up appointment: 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), office visits.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chapter 8 Neck and Upper Back Complaints Page(s): 177, 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic) / Office Visits.

Decision rationale: CA MTUS ACOEM Practice Guidelines state patients whose neck or upper back complaints may be work related should receive follow-up care every three to five days by midlevel practitioner, who can counsel them about avoiding static positions, medication use, activity modification, and other concerns. If the patient has returned to work, these interactions may be done on site or by telephone to avoid interfering with modified-or-full-work activities. Physical follow-up generally occurs when a release to modified, increased or full duty is needed, or after appreciable healing or recovery can be expected, on average. Physician follow-up might be expected every four to seven days if the patient is off work and every seven to fourteen days if the patient is working. CA MTUS ACOEM Practice Guidelines state patients with potentially work-related low back complaints should have follow-up every three to five days by a midlevel practitioner or physical therapist who can counsel the patient about avoiding static positions, medication use, activity modification, and other concerns. Health practitioners should take care to answer questions and make these sessions interactive so that the patient is fully involved in his or her recovery. If the patient has returned to work, these interactions may be conducted on site or by telephone to avoid interfering with modified or full-work activities. Physician follow-up can occur when a release to modified, increased or full duty is needed, or after appreciable healing or recovery can be expected, on average. Physician follow-up might be expected every four to seven days if the patient is off work and seven to fourteen days if the patient is working. Official Disability Guidelines state that office visits are recommended as determined to be medically necessary. Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. 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 determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self-care as soon as clinically feasible. The ODG Codes for Automated Approval (CAA), designed to automate claims management decision-making, indicates the number of E&M office visits (codes 99201-99285) reflecting the typical number of E&M encounters for a diagnosis, but this is not intended to limit or cap the number of E&M encounters that are medically necessary for a particular patient. Office visits that exceed the number of office visits listed in the CAA may serve as a "flag" to payors for possible evaluation, however, payors should not automatically deny payment for these if preauthorization has not been obtained. Note: The high quality medical studies required for treatment guidelines such as ODG provides guidance about specific treatments and diagnostic procedures, but not about the recommended number of E&M office visits. Studies have and are being conducted as to the value of "virtual visits" compared with inpatient visits, however the value of patient/doctor interventions has not been questioned. Further, ODG does provide guidance for therapeutic office visits not included among the E&M codes, for example Chiropractic manipulation and Physical/Occupational therapy. In this case,

the injured worker last worked in 2012. She was not utilizing opioids for ongoing management of chronic pain. She had been utilizing non-steroidal anti-inflammatory topical analgesics for pain which were found to be not medically necessary. The provider requested an MRI and trigger point injections which were also found not medically necessary. As such, the request for a follow-up visit is not medically necessary.