MAXIMUS Federal Services

Case Number:	CM15-0169332		
Date Assigned:	09/14/2015	Date of Injury:	02/22/2013
Decision Date:	11/12/2015	UR Denial Date:	07/30/2015
Priority:	Standard	Application Received:	08/27/2015

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, Florida
Certification(s)/Specialty: Anesthesiology, 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 50 year old female who sustained a work related injury February 22, 2013. While pulling molds from overhead, she lost her grip and they fell onto her right wrist. She developed immediate right wrist pain and pain in her neck, shoulders, right elbow and back. She was diagnosed with a fracture of the right wrist and which was immobilized with a cast. Past history included PT, acupuncture, steroid injections, status post right wrist carpal tunnel release and status post right shoulder arthroscopic decompression March 2015. The 2013 MRI of the right wrist showed mild tendinitis. The 2013 X-ray of the cervical spine showed decrease in disc height and spurring at C5-C6 otherwise no major abnormality. The EMG /NCV studies of the cervical spine / upper extremities showed only right carpal tunnel syndrome. The 2013 MRI of the right shoulder was noted to degenerative joint disease of the glenohumeral and acromio-clavicular joints, tendinosis and tendon tear. According to a doctor's first report of occupational injury or illness dated July 16, 2015, the injured worker presented with complaints of neck pain, back pain, bilateral shoulder pain, right arm-elbow pain and right wrist pain. Physical examination revealed; cervical spine-tenderness to palpation bilateral paraspinal muscles, trapezius muscles, right greater than left, spasms, decreased range of motion, positive compression-shoulder depression tests. Thoracic spine tenderness to palpation and spasm with decreased range of motion; lumbar spine- tenderness to palpation bilateral paraspinal muscles-sacroiliac joints with decreased range of motion; right shoulder-tenderness to palpation, decreased range of motion, positive Neer's, supraspinatus apprehension tests; left shoulder-tenderness to palpation, decreased range of motion, positive Neer's supraspinatus tests; right

wrist- swelling tenderness to palpation, decreased range of motion, Positive Tinel's and Phalen's test; decreased sensation right lateral forearm and hand, middle finger and decreased sensation right upper extremity median nerve distribution. Diagnoses are cervical musculoligamentous sprain, strain with radiculitis; bilateral upper trapezius myofascial pain; thoracic and lumbar musculoligamentous sprain, strain; bilateral shoulder tendinosis. At issue, is the request for authorization for electrodiagnostic studies of the bilateral upper extremities, ECSWT, right shoulder, Flurbi (NAP) Cream, Gabacyclotram, hot and cold unit purchase, interferential unit purchase, MRI, right wrist, physical therapy, Theramine, Tramadol, and x-rays of the lumbosacral spine, shoulders, right wrist and cervical spine. According to utilization review dated July 30, 2015, the request for Tramadol 50mg #60 has been modified to Tramadol 50mg #30. The request for EMG-NCV bilateral upper extremities (electromyogram and nerve conduction velocity studies, bilateral upper extremities) has been modified to EMG-NCV right upper extremity. The request for Flurbi (NAP) Cream LA 180gm is non-certified. The request for Gabacyclotram 180gm is non-certified. The request for Theramine #90 (1) bottle is non-certified. The request for physical therapy and treatment x 12 cervical, thoracic, lumbar spine, shoulders, right wrist is non-certified. The request for an MRI right wrist is non-certified. The request for x-ray's; cervical, lumbosacral spine, shoulders, and right wrist are non-certified. The request for an Interferential Unit has been non-certified. The request for Hot and Cold Unit purchase has been non-certified. The request for ECSWT (extracorporeal shockwave therapy) right shoulder 1 x 4 has been non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Tramadol 50mg, #60: 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): Medications for chronic pain, Opioids, criteria for use, Opioids for chronic pain, Opioids, differentiation: dependence & addiction, Opioids, dosing, Weaning of Medications. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Opioids.

Decision rationale: The CA MTUS and the ODG guidelines recommend that opioids can be utilized for short term treatment of exacerbation of musculoskeletal pain when standard NSAIDs, non opioid co-analgesics and PT have failed. The chronic use of opioids can be associated with the development of tolerance, dependency, addiction, sedation and adverse interaction with other sedative agents. The records did not show that the patient failed treatment with NSAIDs and non opioid co-analgesics. There was no documentation of guidelines required compliance monitoring of serial UDS, CURESS data reports, absence of aberrant behavior and functional restoration. The criteria for the use of tramadol 50mg #60 was not met. Therefore the request is not medically necessary.

Flurbi (NAP) Cream-LA 180gm: 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): Amitriptyline, Antidepressants for chronic pain, Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Topical Analgesics Antidepressants.

Decision rationale: The CA MTUS and the ODG guidelines recommend that topical analgesics can be utilized for the treatment of localized neuropathic pain when first line orally administered anticonvulsant and antidepressant medications have failed. The records did not show subjective or objective findings consistent with a diagnosis of localized neuropathic pain such as CRPS. There is no documentation of failure of first line medications. The guidelines recommend that topical medications be utilized individually for evaluation of efficacy. There is lack of guidelines support or the utilization of topical formulations of amitriptyline in the treatment of chronic musculoskeletal pain. The Flurbi NAP contains flurbiprofen 20% / lidocaine 5% / amitriptyline 4%. The criteria for the use of Flurbi (NAP) cream-LA 180gm / Gabacyclotram 180mg was not met. The request is not medically necessary.

Gabacyclotram 180gm: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Antiepilepsy drugs (AEDs), Medications for chronic pain, Opioids, specific drug list, Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Topical Analgesics Opioids Anticonvulsants.

Decision rationale: The CA MTUS and the ODG guidelines recommend that topical analgesics can be utilized for the treatment of localized neuropathic pain when first line orally administered anticonvulsant and antidepressant medications have failed. The records did not show subjective or objective findings consistent with a diagnosis of localized neuropathic pain such as CRPS. There is no documentation of failure of first line medications. The guidelines recommend that topical medications be utilized individually for evaluation of efficacy. There is lack of guidelines support or the utilization of topical formulations of cyclobenzaprine or tramadol in the treatment of chronic musculoskeletal pain. The Gabacyclotram contains gabapentin 6% / tramadol 10% in lidocaine base. The criteria for the use of Gabacyclotram 180mg was not met. The request is not medically necessary.

Theramine #90 (1 bottle): 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): Medications for chronic pain, Nonprescription medications. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Medical Food.

Decision rationale: The CA MTUS and the ODG guidelines did not support the prescription of Medical Food products including theramine because of absence of data to support objective findings of sustained beneficial effects. Theramine is also available as an OTC product that is marketed to have anti-inflammatory effect. The patient is utilizing prescription medications with anti-inflammatory action concurrently. The criteria for the use of Theramine #90 1 bottle was not met. The request is not medically necessary.

Interferential Unit, purchase: 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): Electrical stimulators (E-stim), Physical Medicine, Transcutaneous electrotherapy. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Stimulation Therapy.

Decision rationale: The CA MTUS and the ODG guidelines did not support the use of Interferential Unit in the treatment of chronic musculoskeletal pain. The guidelines noted a lack of sustained objective findings of functional restoration with the use of Interferential Unit therapy beyond the supervised PT setting or after the immediate post injury period. The records indicate that the musculoskeletal pain is located in multiple spine and extremities regions that are not amenable to simultaneous topical treatment measures. The criteria for the use of Interferential Unit purchase was not met. The request is not medically necessary.

Hot & Cold Unit, purchase: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Hot /Cold Therapy.

Decision rationale: The CA MTUS and the ODG guidelines did not support the use of Hot /Cold Unit in the treatment of chronic musculoskeletal pain. The use of Hot /Cold therapy can be associated with reduction in pain and swelling and functional restoration. The guidelines noted the lack of sustained objective findings of functional restoration with the use of Hot and Cold therapy beyond the supervised PT setting and after the immediate post injury period. The records indicate that the musculoskeletal pain is located in multiple spine and extremities regions that is not amenable to topical Hot/Cold treatment measures. The criteria for the use of Hot & Cold Unit purchase was not met. The request is not medically necessary.

Extracorporeal Shockwave Therapy (ECSWT) to the right shoulder 1 x 4: 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): Electrical stimulators (E-stim), Transcutaneous electrotherapy, Ultrasound, therapeutic. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Extracorporeal Shockwave Therapy.

Decision rationale: The CA MTUS and the ODG guidelines did not support the use of Extracorporeal Shockwave Therapy (ECSWT) in the treatment of generalized chronic musculoskeletal pain. The guidelines noted lack of sustained objective findings of functional restoration with the use of ECSWT beyond the supervised PT setting or after the immediate post injury period. The guidelines noted limited beneficial effects with the use of ECSWT for limited conditions including lateral epicondylitis and shoulder tendinitis. The records indicate that the musculoskeletal pain is located in multiple spine and extremities regions that is not amenable to topical treatment measures. The criteria for the use of Extracorporeal Shockwave Therapy (ECSWT) to the right shoulder 1X 4 was not met. The request is not medically necessary.

MRI to the right wrist: Upheld

Claims Administrator guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Upper Extremities.

Decision rationale: The CA MTUS and the ODG guidelines recommend that radiological tests can be utilized for the evaluation of worsening musculoskeletal disorders when conservative treatments with medications and PT have failed. The MRI studies is further indicated when clinical examinations and standard X-ray test are inconclusive. The records showed that the musculoskeletal pain had been fully evaluated by radiological tests. The previous X-rays and MRI of the right wrist did not show significant abnormality. There is no clinical indication of further deterioration of the condition since the last radiological investigations. The criteria for the MRI of the right wrist was not met. The request is not medically necessary.

Physical Therapy, evaluation and treatment, 12 sessions, to the cervical, thoracic and lumbar spine, shoulders, and right wrist: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004, and Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Exercise, Manual therapy & manipulation, Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Physical Therapy.

Decision rationale: The CA MTUS and the ODG guidelines recommend that Physical Therapy (PT) can be utilized for the treatment of exacerbation of musculoskeletal pain. The utilization of PT for the treatment of musculoskeletal pain can lead to reduction in pain, decreased medication utilization and functional restoration. The guidelines recommend that patient proceed to a home exercise program after completion supervised PT. The records indicate that the patient had previously completed series of supervised PT programs. There is no documentation of re-injury or exacerbation of the chronic pain syndrome. The criteria for Physical Therapy, evaluation and treatment, 12 sessions to the cervical, thoracic and lumbar spines, shoulders and right wrist was not met. The request is not medically necessary.

X-ray to the cervical spine: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004.

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

Decision rationale: The CA MTUS and the ODG guidelines recommend that radiological tests can be utilized for the evaluation of worsening musculoskeletal disorders when conservative treatments with medications and PT have failed. The repeat X-ray or MRI studies is further indicated when clinical examinations and previous X-ray test are inconclusive. The records showed that the musculoskeletal pain had been fully evaluated by radiological tests. The previous X-rays and MRI of the cervical spine did not show significant abnormality. There is no clinical indication of further deterioration of the condition or neurological deficit since the last radiological investigations. The criteria for X-ray of the cervical spine was not met. The request is not medically necessary.

X-Ray of the Lumbosacral Spine: Upheld

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

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

Decision rationale: The CA MTUS and the ODG guidelines recommend that radiological tests can be utilized for the evaluation of worsening musculoskeletal disorders when conservative treatments with medications and PT have failed. The repeat X-rays or MRI studies is further indicated when clinical examinations and previous X-ray test are inconclusive. The records showed that the musculoskeletal pain had been fully evaluated by radiological tests. The

previous X-rays and MRI of the low back did not show significant abnormality or neurological deficit. There is no clinical indication of further deterioration of the lumbar spine condition since the last radiological investigations. The criteria for X-ray of the lumbar spine was not met. The request is not medically necessary.

X-Ray of the Shoulders: Upheld

Claims Administrator guideline: Decision based on MTUS Shoulder Complaints 2004.

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

Decision rationale: The CA MTUS and the ODG guidelines recommend that radiological tests can be utilized for the evaluation of worsening musculoskeletal disorders when conservative treatments with medications and PT have failed. The X-rays or MRI studies can be repeated when clinical examinations and standard X-ray test are inconclusive. The records showed that the musculoskeletal pain had been fully evaluated by radiological tests. The previous MRI of the shoulders showed significant abnormalities that were treated by arthroscopic decompressive surgery. There is no clinical indication of further deterioration of the shoulder conditions since the last radiological investigations and surgery. The criteria for X-ray of the shoulders was not met. The request is not medically necessary.

X-Ray of the right wrist: Upheld

Claims Administrator guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004.

MAXIMUS guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Upper Extremities.

Decision rationale: The CA MTUS and the ODG guidelines recommend that radiological tests can be utilized for the evaluation of worsening musculoskeletal disorders when conservative treatments with medications and PT have failed. The radiological studies are further indicated when clinical examinations are inconclusive. The records showed that the musculoskeletal pain had been fully evaluated by radiological tests. The previous X-rays and MRI of the wrist did not show significant abnormality. There is no clinical indication of further deterioration of the condition since the last set of radiological investigations. The criteria for X-ray of the right wrist was not met. The request is not medically necessary.

EMG/NCV of the bilateral upper extremities: Upheld

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

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Diagnostic Criteria, Special Studies, and Forearm, Wrist, and Hand Complaints 2004, Section(s): Diagnostic Criteria, Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter EMG/NCV Studies.

Decision rationale: The CA MTUS and the ODG guidelines recommend that EMG/NCV studies can be utilized for evaluation of neurological deficits associated with neck and upper extremities conditions. The use of EMG/NCV studies is indicated when clinical examinations and radiological tests are inconclusive. The records indicate that the patient completed EMG / NCV studies of the upper extremities that sis not show significant findings except for right carpal tunnel syndrome. There is no documentation of subjective or objective findings of worsening radiculopathy or neuropathy of the upper extremities since completion of the last set of upper extremities EMG/NCV studies. The criteria for EMG/NCV studies of the upper extremities was not met. The request is not medically necessary.