

Case Number:	CM15-0172362		
Date Assigned:	09/15/2015	Date of Injury:	12/16/2014
Decision Date:	11/09/2015	UR Denial Date:	08/18/2015
Priority:	Standard	Application Received:	09/01/2015

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: 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 37 year old male, who sustained an industrial-work injury on 12-16-14. A review of the medical records indicates that the injured worker is undergoing treatment for low back pain, lumbago, facet arthropathy, lumbar disc displacement, lumbosacral radiculopathy, myofascial dysfunction, cephalgia, cervical radiculopathy, cervical strain and sprain, thoracic strain and sprain, thoracic strain and sprain, insomnia, anxiety and depression. Medical records dated (3-5-15 to 7-20-15) indicate that the injured worker complains of neck pain with radiation to the upper extremities with numbness and tingling. There is upper back pain associated with numbness. There is low back pain that radiates to both legs with numbness and weakness. There are intermittent throbbing headaches and complaints of loss of sleep due to pain, anxiety and depression. The medical records dated 5-27-15 to 7-20-15 the injured worker rates the pain from 4-8 out of 10 on pain scale without medications and 2-4 out of 10 with medications. This has been unchanged. The medical records also indicate worsening of the activities of daily living due to pain. Per the treating physician report dated 7-20-15 the injured worker is temporarily totally disabled for 45 days. The physical exam dated 7-20-15 reveals that he appears to be anxious and depressed and has mild distress due to pain. The cervical spine shows tenderness to palpation, tenderness and myospasm noted over the bilateral paracervical muscles and bilateral trapezius muscles. There is trigger points with positive taut bands, twitched response, positive jump sign with pressure over the bilateral paracervical muscles. The foraminal compression and cervical distraction tests are positive bilaterally. There is decreased cervical range of motion in all planes due to end range neck pain. There is parathoracic tenderness,

spasm, trigger points, positive taut bands, twitched response, positive jump sign with pressure over the bilateral paralumbar muscles. There is decreased thoracic range of motion due to end range middle back pain. There is tenderness and spasm over the lumbar paraspinal muscles, tenderness in the sciatic notches, trigger points with positive taut bands, twitched response, positive jump sign with pressure over the bilateral paralumbar muscles. The straight leg raise is positive bilaterally causing low back pain that radiates to the posterior thigh upon 45 degrees of right leg raising. There is decreased lumbar range of motion in all planes due to end range back pain. There is decreased sensation of the upper extremities and reduced motor strength. Treatment to date has included pain medication and compound creams, trigger point injections times four on 5-5-15, diagnostics, back brace, massage therapy, ultrasound, electrical stimulation, other modalities and home exercise program (HEP). The Magnetic resonance imaging (MRI) of the lumbar spine dated 3-3-15 reveals retrolisthesis and bilateral neural foraminal narrowing with right disc protrusion impinging on the right nerve root. Findings can be associated with right S1 radiculopathy. The physician indicates the x-ray of the lumbar spine dated 12-17-14 shows an ambiguous number of lumbar vertebral bodies, no evidence of acute change or instability and minimal anterior osteophytic lipping. The original Utilization review dated 8-18-15 non-certified a request for Amitriptyline 10 Percent, Gabapentin 10 Percent, Bupivacaine 5 Percent, Hyaluronic Acid 0.2 Percent Cream 240gm, as it is not recommended by the guidelines, non-certified a request for Flurbiprofen 20 Percent, Baclofen 5 Percent, Dexamethasone 0.2 Percent, Menthol 2 Percent, Camphor 2 Percent, Capsaicin 0.025 Percent, Hyaluronic Acid 0.2 Percent Cream 240gm as it is not recommended by the guidelines, non-certified a request for X-Ray Cervical Spine as the symptoms are chronic and there has been no significant changes therefore, not medically necessary, non-certified a request for X-Ray Thoracic Spine, as the symptoms are chronic and there has been no significant changes therefore, not medically necessary, non-certified a request for Magnetic Resonance Imaging (MRI Cervical Spine) as the injured worker had previous Magnetic Resonance Imaging (MRI) Magnetic Resonance Imaging and the symptoms are chronic and there has been no significant changes therefore, not medically necessary, non-certified a request for (MRI) Thoracic Spine as the injured worker had previous Magnetic Resonance Imaging (MRI) Magnetic Resonance Imaging and the symptoms are chronic and there has been no significant changes therefore, not medically necessary, non-certified a request for electrodes, Lead Wires, Adapter, and Multi Stimulator Unit (Unspecified If For Purchase Or Rental) as it is not recommended by the guidelines as a primary treatment modality therefore, not medically necessary, non-certified a request for Magnetic Resonance Imaging (MRI) of the Lumbar Spine as the injured worker had previous Magnetic Resonance Imaging (MRI) Magnetic Resonance Imaging and the symptoms are chronic and there has been no significant changes therefore, not medically necessary, non-certified a request for electromyography (EMG) and/or nerve conduction velocity studies (NCV) of the bilateral lower extremities as there is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy, per the guidelines not medically necessary, and non-certified a request for electromyography (EMG) and/or nerve conduction velocity studies (NCV) of the lumbar spine as there is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy, therefore per the guidelines not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Amitriptyline 10 Percent, Gabapentin 10 Percent, Bupivacaine 5 Percent, Hyaluronic Acid 0.2 Percent Cream 240gm: 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: According to the MTUS, there is little to no research to support the use of many of these compounded topical analgesics. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Gabapentin is not recommended. There is no peer-reviewed literature to support use. Amitriptyline 10 Percent, Gabapentin 10 Percent, Bupivacaine 5 Percent, Hyaluronic Acid 0.2 Percent Cream 240gm is not medically necessary.

Flurbiprofen 20 Percent, Baclofen 5 Percent, Dexamethasone 0.2 Percent, Menthol 2 Percent, Camphor 2 Percent, Capsaicin 0.025 Percent, Hyaluronic Acid 0.2 Percent Cream 240gm: 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: According to the MTUS, there is little to no research to support the use of many of these Compounded Topical Analgesics. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Flurbiprofen topical is not supported by the MTUS. Flurbiprofen 20 Percent, Baclofen 5 Percent, Dexamethasone 0.2 Percent, Menthol 2 Percent, Camphor 2 Percent, Capsaicin 0.025 Percent, Hyaluronic Acid 0.2 Percent Cream 240gm is not medically necessary.

X-Ray Cervical Spine: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back-Lumbar and Thoracic (Acute and Chronic).

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies.

Decision rationale: According to the MTUS, special studies such as a cervical x-ray are not needed unless a red-flag condition is present. Cervical radiographs are most appropriate for patients with acute trauma associated with midline vertebral tenderness, head injury, drug or

alcohol intoxication, or neurologic compromise. There is no documentation of any of the above criteria. X-Ray Cervical Spine is not medically necessary.

X-Ray Thoracic Spine: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back-Lumbar and Thoracic (Acute and Chronic).

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

Decision rationale: The MTUS states that radiographs of the thoracic spine are indicated when red flags are present indicating fracture, cancer, or infection. The medical record contains no documentation of red flags indicating that a thoracic x-ray is appropriate. At present, based on the records provided, and the evidence-based guideline review, the request is non-certified. X-Ray Thoracic Spine is not medically necessary.

MRI Cervical Spine: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Low back -Lumbar and Thoracic (Acute and Chronic).

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies.

Decision rationale: The MTUS states that an MRI or CT is recommended to validate diagnosis of nerve root compromise, based on clear history and physical examination findings, in preparation for invasive procedure. In addition, the ACOEM Guidelines state the following criteria for ordering imaging studies: 1. Emergence of a red flag, 2. Physiologic evidence of tissue insult or neurologic dysfunction, 3. Failure to progress in a strengthening program intended to avoid surgery, 4. Clarification of the anatomy prior to an invasive procedure. There is no documentation of any of the above criteria supporting a recommendation of a cervical MRI. MRI Cervical Spine is not medically necessary.

MRI Thoracic Spine: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back - Lumbar and Thoracic.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), MRIs (magnetic resonance imaging).

Decision rationale: The Official Disability Guidelines state that indications for a thoracic MRI include trauma, thoracic pain suspicious for cancer or infection, cauda equina syndrome, or myelopathy. The exam indicates that the patient has complaining of mid back pain without evidence of long track signs, bowel or bladder dysfunction, or progressive neurologic deficit. There is no documentation of any of the above criteria supporting a recommendation of a thoracic MRI. MRI Thoracic Spine is not medically necessary.

Electrodes: 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: Multiple stimulation units are not recommended by the MTUS. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue, shoulder pain, cervical neck pain and knee pain. There are no standardized protocols for the use of interferential therapy; and the therapy may vary according to the frequency of stimulation, the pulse duration, treatment time, and electrode-placement technique. Electrodes are not medically necessary.

Lead Wires: 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: Multiple stimulation units are not recommended by the MTUS. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue, shoulder pain, cervical neck pain and knee pain. There are no standardized protocols for the use of interferential therapy; and the therapy may vary according to the frequency of stimulation, the pulse duration, treatment time, and electrode-placement technique. Lead Wires are not medically necessary.

Adapter: 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: Multiple stimulation units are not recommended by the MTUS. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue, shoulder pain, cervical neck pain and knee pain. There are no standardized protocols for the use of interferential therapy; and the therapy may vary according to the frequency of stimulation, the pulse duration, treatment time, and electrode-placement technique. Adapter is not medically necessary.

Multi Stim Unit (Unspecified if for Purchase or Rental): 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: Multiple stimulation units are not recommended by the MTUS. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue, shoulder pain, cervical neck pain and knee pain. There are no standardized protocols for the use of interferential therapy; and the therapy may vary according to the frequency of stimulation, the pulse duration, treatment time, and electrode-placement technique. Multi Stim Unit (Unspecified if for Purchase or Rental) is not medically necessary.

MRI of the Lumbar 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 rationale: The MTUS states that unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. The medical records fail to document sufficient findings indicative of nerve root compromise, which would warrant an MRI of the lumbar spine. MRI of the Lumbar Spine is not medically necessary.

EMG and/or NCV of the bilateral 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: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), EMGs (electromyography).

Decision rationale: According to the Official Disability Guidelines, EMG's are recommended as an option and may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. The clinical information submitted for review fails to meet the evidence-based guidelines for the requested service. EMG and/or NCV of the bilateral lower extremities is not medically necessary.

EMG and/or NCV 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, Low Back.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Nerve conduction studies (NCS).

Decision rationale: According to the Official Disability Guidelines, EMG's are recommended as an option and may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. The clinical information submitted for review fails to meet the evidence-based guidelines for the requested service. EMG and/or NCV of the bilateral lower extremities is not medically necessary.