MAXIMUS Federal Services

| Case Number: | CM15-0173480 | | |
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| Date Assigned: | 09/24/2015 | Date of Injury: | 05/14/2015 |
| Decision Date: | 11/25/2015 | UR Denial Date: | 08/18/2015 |
| Priority: | Standard | Application Received: | 09/02/2015 |

## 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: New York, California
Certification(s)/Specialty: Emergency 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:

This is a 49-year-old male, whose date of injury was May 14, 2015. The medical records indicated the injured worker reported a low back injury on September 14, 2012 and cumulative trauma injuries of which he developed pain in both wrists and hands to 5-14-2015. A doctor's first report of occupation injury or illness on July 13, 2015 revealed the injured worker's subjective complaints included burning radicular neck pain, burning bilateral wrist and hand pain, burning radicular mid back pain and burning radicular low back pain. On physical examination, the injured worker had tenderness to palpation over the cervical paraspinal muscles bilateral and decreased range of motion. He had diminished sensation to pinprick and light touch. Motor strength was 4-5 in all represented muscle groups in the upper extremities. There was tenderness to palpation at the trapezius and over the bilateral thoracic paraspinal muscles with decreased range of motion. Dermatomes of the thoracic spine were within normal limits. He had tenderness to palpation at the lumbar paraspinal muscles and over the lumbosacral junction with decreased range of motion. He had decreased sensation to pinprick and light touch over the lumbar spine and lumbar motor strength was 4-5 in all muscle groups in the lower extremities. Diagnoses included cervical spine sprain-strain, rule out herniated nucleus pulposus, rule out cervical radiculopathy, bilateral wrist and hand pain, rule out bilateral wrist carpal tunnel syndrome, rule out bilateral hand tenosynovitis, thoracic spine sprain-strain, rule out herniated nucleus pulposus, lumbar spine sprain-strain rule out herniated nucleus pulposus and rule out lumbar radiculopathy. A request for authorization was received on August 12, 2015 for the following: Deprizine, Dicopanol, Fanatrex, Synapryn, Tabradol, Cyclobenzaprine, Ketoprofen cream, Compound HMPC2 cream, Compound HNPC1 cream, Urine drug screen, cervical x-ray, cervical MRI, Thoracic X-ray, Thoracic MRI, Lumbar X-ray, Lumbar MRI, Bilateral hand x-ray, bilateral hand

MRI, bilateral wrist x-ray, bilateral wrist MRI, bilateral upper extremity EMG, bilateral upper extremity NCV, bilateral lower extremity EMG, bilateral lower extremity NCV, physical therapy for the cervical spine and lumbar spine #18, chiropractic therapy for the cervical spine and lumbar spine #18, acupuncture therapy for the cervical spine and lumbar spine #18, shockwave therapy for the bilateral wrists-hands #3, shockwave therapy for the cervical, thoracic and lumbar spine #6, TENS unit, Hot-Cold Unit and referral to pain management specialist for consultation regarding epidural steroid injections for the thoracic spine. On August 18, 2015, the Utilization Review physician determined Deprizine, Dicopanol, Fanatrex, Synapryn, Tabradol, Cyclobenzaprine, Ketoprofen cream, Compound HMPC2 cream, Compound HNPC1 cream, Urine drug screen, cervical x-ray, cervical MRI, Thoracic X-ray, Thoracic MRI, Lumbar X-ray, Lumbar MRI, Bilateral hand x-ray, bilateral hand MRI, bilateral wrist x-ray, bilateral wrist MRI, bilateral upper extremity EMG, bilateral upper extremity NCV, bilateral lower extremity EMG, bilateral lower extremity NCV, chiropractic therapy for the cervical spine and lumbar spine #18, acupuncture therapy for the cervical spine and lumbar spine #18, shockwave therapy for the bilateral wrists-hands #3, shockwave therapy for the cervical, thoracic and lumbar spine #6, TENS unit, Hot-Cold Unit and referral to pain management specialist for consultation regarding epidural steroid injections for the thoracic spine was not medically necessary and modified physical therapy for the cervical spine and lumbar spine #18 to physical therapy for the cervical and lumbar spine #6 based on the CA MTUS Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Deprizine:** 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): NSAIDs, GI symptoms & cardiovascular risk.

**Decision rationale:** Deprizine is the oral solution equivalent of ranitidine. According to CA MTUS, gastrointestinal protectant agents are recommended for patients that are at increased risk for gastrointestinal events. These risks include age > 65, history or gastrointestinal bleeding or peptic ulcers, concomitant use of NSAIDs and corticosteroids or aspirin, or high dose NSAID use. The chart does not document any of these risk factors. Past medical history does not include any gastrointestinal disorders, there is no history of poor tolerance to NSAIDs documented and there are not abdominal examinations noted in the chart. Additionally, the request does not include dosing or frequency. Without the support of the documentation, the request for Deprizine is not medically necessary based on the MTUS.

**Dicopanol:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Drugs.com Website (http://www.drugs.com/pro/dicopanol.html).

**Decision rationale:** The CA MTUS and ODG are silent with respect to this medication. According to the above reference, Dicopanol is a combination of antihistamine and other proprietary ingredients. Unknown components of a medication cannot be evaluated to determine their safety or medical necessity. Additionally, the request does not include dosing or frequency. Without the support of the documentation and the unknown ingredients, the request for Dicopanol is not medically necessary.

**Fanatrex:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Drugs.com Website (http://www.drugs.com/pro/fanatrex.html).

**Decision rationale:** The CA MTUS and ODG are silent regarding this treatment. According to the above reference, Fanatrex is a combination of gabapentin and other proprietary ingredients. Unknown components of a medication cannot be evaluated to determine their safety or medical necessity. Additionally, the request does not include dosing or frequency. Without the support of the documentation and the unknown ingredients, the request for Fanatrex is not medically necessary.

**Synapryn:** 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): Opioids, specific drug list, Opioids for chronic pain. Decision based on Non-MTUS Citation BioPortfolio http://www.bioportfolio.com/resources/drug/22213/Synapryn.html.

**Decision rationale:** Synapryn is a compounded substance that includes Tramadol as a primary ingredient and typically glucosamine as a second ingredient. While Tramadol is discussed in CA MTUS, this compounded formulation is not. ODG is also silent on this substance. Tramadol is a synthetic opioid that is typically prescribed for as needed dosing for pain control. The indications specific to Tramadol are not apparent in chart documentation. The dosing, frequency and effects are not stated. The other component, glucosamine, is recommended as an option for the treatment of moderate arthritic pain, mainly the knees. The IW does not have an active diagnosis of arthritis. The combination of these medications is not supported as one is intended for as needed breakthrough pain and carries substantial medical risks due to its potential accumulative effect. The other is for moderate pain caused by osteoarthritis and is used more liberally without the same toxicological profile. Additionally, the request does not include dosing or frequency. Without the support of the documentation and a combination preparation that is not supported, Synapryn is not medically necessary.

**Tabradol:** 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): Cyclobenzaprine (Flexeril).

**Decision rationale:** Tabradol is an oral solution of cyclobenzaprine. According to CA MTUS, this medication is recommended only for a short course of therapy. The effect is noted to be greatest in the first 4 days of treatment, therefore not supportive for use in chronic pain. Additionally, cyclobenzaprine is not recommended to be added to other agents. The request does not include dosing or frequency. It should also be noted this medication in a different formulation has been simultaneously requested. It should also be noted this medication in a different formulation has been simultaneously requested. For all of these reasons, cyclobenzaprine is not medically necessary.

**Cyclobenzaprine:** 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): Cyclobenzaprine (Flexeril).

**Decision rationale:** According to CA MTUS, this medication is recommended only for a short course of therapy. The effect is noted to be greatest in the first 4 days of treatment, therefore not supportive for use in chronic pain. Additionally, cyclobenzaprine is not recommended to be added to other agents. The request does not include dosing or frequency. For all of these reasons, cyclobenzaprine is not medically necessary.

**Ketoprofen cream #1:** 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:** The CA MTUS guidelines for topical analgesic agents are referenced above. According to these guidelines, Ketoprofen is not currently FDA approved for topical application. This medication is known to have high incidence of photo-contact dermatitis. Additionally, the request does not include the dosing, frequency, or location of application. As this medication is not supported by the guidelines or FDA approved, the request is not medically necessary.

**Compound HMPC2 cream:** 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:** The CA MTUS chronic pain guidelines, topical analgesics are "largely experimental in use with few randomized controlled trials to determine efficacy or safety." Guidelines also state, "Many agents are compounded as monotherapy or in combination for pain

control. There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug that in not recommended is not recommended." The documentation state this compound cream includes flurbiprofen, baclofen, Dexamethasone micro, hyaluronic acid. According to MTUS guidelines, Baclofen is not recommended, as there is no peer reviewed literature to support its use. Additionally, the request does not include dosing frequency, duration, or site of application. The request for compound HMPC2 cream is not medically necessary.

**Compound HNPC1 cream:** 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:** The CA MTUS chronic pain guidelines, topical analgesics are "largely experimental in use with few randomized controlled trials to determine efficacy or safety." Guidelines also state, "Many agents are compounded as monotherapy or in combination for pain control. There is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug that in not recommended is not recommended." Documentation lists the components of this cream to include Amitriptyline HCL, Gabapentin, Bupivacaine HCL, and hyaluronic acid. According to CA MTUS guidelines, topical gabapentin is not recommended, as there is no peer reviewed literature to support its use. Additionally, the request does not include dosing frequency, duration, or site of application. The request for compound HNPC1 cream is not medically necessary.

**Urine drug screen:** 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, screening for risk of addiction (tests), Opioids, steps to avoid misuse/addiction.

**Decision rationale:** The CA MTUS recommends drug testing as an option to "assess for the use or the presence of illegal drugs." The request does not include testing protocols. In addition, the request for a UA drug screen does not specify what specifically is being tested. The specific content of the test should be listed, as many drug tests do not assay the correct drugs. The urine drug screen is not medically necessary based on lack of a clear collection and testing protocol, lack of details regarding the testing content and protocol, and lack of a current opioid therapy program, which is in accordance with the MTUS.

**X-ray of 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): Diagnostic Criteria, Special Studies.

**Decision rationale:** According to MTUS guidelines, imaging of the cervical spine is not indicated unless symptoms extend beyond 3-4 weeks of conservative care. The exception is for red flag conditions such as evidence of neurologic dysfunction, failure to progress in a strengthening program, or for anatomy clarification in anticipation of surgery. Further guidelines state, Cervical radiographs are most appropriate for patients with acute trauma associated with midline vertebral tenderness, head injury, drug or alcohol intoxication, or neurologic compromise. The records do not support any of these guidelines. The IW does not have midline bony tenderness and there is no documentation of acute trauma. There is no documentation of conservative treatments such as physical medicine treatments or response to prescribed analgesics. Without this supporting documentation, the request for cervical radiography are not medically necessary.

**MRI of 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): Diagnostic Criteria, Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back: MRI.

**Decision rationale:** The CA MTUS ACOEM guidelines recommends imaging studies for cases "in which surgery is considered or red-flag diagnoses are being evaluated." With respect to cervical magnetic resonance imaging studies, other indications include neck, shoulder, posterior arm pain, paresthesia, or post laminectomy syndrome. ODG guidelines recommend an MRI for the following indications only: Chronic neck pain (= after 3 months conservative treatment), radiographs normal, neurologic signs or symptoms present. Neck pain with radiculopathy if severe or progressive neurologic deficit. Chronic neck pain, radiographs show spondylosis, neurologic signs or symptoms present. Chronic neck pain, radiographs show old trauma, neurologic signs or symptoms present. Chronic neck pain, radiographs show bone or disc margin destruction. Suspected cervical spine trauma, neck pain, clinical findings suggest ligamentous injury sprain), radiographs and/or CT "normal". Known cervical spine trauma: equivocal or positive plain films with neurological deficit. Upper back/thoracic spine trauma with neurological deficit. The IW does not have any of these indications. There is no mention in the record that the IW experienced cervical trauma. There have not been cervical spine radiographs. In the absence of appropriate indications or physical exam finding, the request for a cervical MRI is not medically necessary.

**X-ray of the thoracic spine:** 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. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back: radiographs.

**Decision rationale:** According to MTUS guidelines, imaging of the thoracic spine is not indicated unless symptoms extend beyond 3-4 weeks of conservative care. The exception is for red flag conditions such as evidence of neurologic dysfunction, failure to progress in a

strengthening program, or for anatomy clarification in anticipation of surgery. The IW does not have midline bony tenderness and there is no documentation of acute trauma. There is no documentation of conservative treatments such as physical medicine treatments or response to prescribed analgesics. Without this supporting documentation, the request for cervical radiography are not medically necessary.

**MRI of the thoracic 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): Diagnostic Criteria, Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back: MRI.

**Decision rationale:** The CA MTUS ACOEM guidelines recommends imaging studies for cases "in which surgery is considered or red-flag diagnoses are being evaluated." "Criteria for ordering imaging studies are: emergence of a red flag, physiologic evidence of tissue insult or neurologic dysfunction, failure to progress in a strengthening program intended to avoid surgery; clarification of the anatomy prior to an invasive procedure." ODG guidelines state MRI is not recommend except with specific conditions. These conditions include: Chronic neck pain (= after 3 months conservative treatment), radiographs normal, neurologic signs or symptoms present. Neck pain with radiculopathy if severe or progressive neurologic deficit. Chronic neck pain, radiographs show spondylosis, neurologic signs or symptoms present. Chronic neck pain, radiographs show old trauma, neurologic signs or symptoms present. Chronic neck pain, radiographs show bone or disc margin destruction. Suspected cervical spine trauma, neck pain, clinical findings suggest ligamentous injury (sprain), radiographs and/or CT "normal". Known cervical spine trauma: equivocal or positive plain films with neurological deficit. Upper back/thoracic spine trauma with neurological deficit. The documentation does not support the IW has any of these conditions. There are not documented subjective or objective neurologic concerns. There is no history of direct trauma. Without the support of guidelines, the request for thoracic MRI is not medically necessary.

**X-ray 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): Diagnostic Criteria, Special Studies.

**Decision rationale:** According to the above referenced guidelines, lumbar imaging is recommended only for IW with red flag conditions. The recommendations further states "In the absence of red flags, imaging and other tests are not usually helpful during the first four to six weeks of low back symptoms." Additionally, documentations the IW has previously had imaging of the lumbar spine. These are not available for review. There is no documentation of new trauma. The documentation does not support indications; therefore, request for lumbar x-rays are 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): Diagnostic Criteria, Special Studies. Decision based on Non-MTUS Official Disability Guidelines, Neck and Upper Back: MRI.

**Decision rationale:** The CA MTUS ACOEM guidelines recommends imaging studies "If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computed tomography [CT] for bony structures)." ODG guidelines state MRI "Recommended for indications below. MRI's are test of choice for patients with prior back surgery, but for uncomplicated low back pain, with radiculopathy, not recommended until after at least one month conservative therapy, sooner if severe or progressive neurologic deficit." The documentation does not support the IW has any of these conditions. There are not documented subjective or objective neurologic concerns. There is no history of direct trauma. Additionally, the records suggest the IW has previously had a previous lumbar MRI. This study in not provided for review. Documents further state, "Repeat MRI: When there is significant change in symptoms and/or findings suggestive of significant pathology (e.g., tumor, infection, fracture, neuro-compression, recurrent disc herniation)." Without the support of guidelines, the request for lumbar MRI is not medically necessary.

**X-ray of the bilateral hands:** 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): Diagnostic Criteria, Special Studies. Decision based on Non-MTUS Official Disability Guidelines, Forearm, Wrist and Hand: radiographs.

**Decision rationale:** The CA MTUS guideline regarding evaluation of hand pain state that for most patients presenting with true hand and wrist problems, special studies are not needed until after a four to six-week period of conservative care and observation. ODG guidelines recommend hand radiographs for the following indications: Acute hand or wrist trauma, wrist trauma, first exam. Acute hand or wrist trauma, suspect acute scaphoid fracture, first exam, plus cast and repeat radiographs in 10-14 days. Acute hand or wrist trauma, suspect distal radio-ulnar joint subluxation. Acute hand or wrist trauma, suspect hook of the hamate fracture. Acute hand or wrist trauma, suspect metacarpal fracture or dislocation. Acute hand or wrist trauma, suspect phalangeal fracture or dislocation. Acute hand or wrist trauma, suspect thumb fracture or dislocation. Acute hand or wrist trauma, suspect gamekeeper injury (thumb MCP ulnar collateral ligament injury). Chronic wrist pain, first study obtained in-patients with chronic wrist pain with or without prior injury, no specific area of pain specified. The IW reports cumulative trauma to the hands. There is no acute trauma documented. Without the support of the documentation, the request for bilateral hand radiographs is not medically necessary.

**MRI of the bilateral hands:** 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): Diagnostic Criteria, Special Studies. Decision based on Non-MTUS Official Disability Guidelines, Forearm, Wrist and Hand: radiographs.

**Decision rationale:** The CA MTUS guideline regarding evaluation of hand pain state that "for most patients presenting with true hand and wrist problems, special studies are not needed until after a four to six-week period of conservative care and observation." ODG guidelines recommend hand MRI for the following clinical conditions: Acute hand or wrist trauma, suspect acute distal radius fracture, radiographs normal, next procedure if immediate confirmation or exclusion of fracture is required. Acute hand or wrist trauma, suspect acute scaphoid fracture, radiographs normal, next procedure if immediate confirmation or exclusion of fracture is required. Acute hand or wrist trauma, suspect gamekeeper injury (thumb MCP ulnar collateral ligament injury). Chronic wrist pain, plain films normal, suspect soft tissue tumor. Chronic wrist pain, plain film normal or equivocal, suspect Kienböck's disease. The IW reports cumulative trauma, not acute injury. The IW has not been evaluated by a hand surgeon. There is no specific diagnostic concerned in the records that necessitates an MRI. There have not been any plain radiographs. Without the support of the documentation or adherence to the guidelines, the request for bilateral MRI studies is not medically necessary.

**X-ray of the bilateral wrists:** 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): Diagnostic Criteria, Special Studies. Decision based on Non-MTUS Official Disability Guidelines, Forearm, Wrist and Hand: radiographs.

**Decision rationale:** The CA MTUS guideline regarding evaluation of hand pain state that for most patients presenting with true hand and wrist problems, special studies are not needed until after a four to six-week period of conservative care and observation. ODG guidelines recommend hand radiographs for the following indications:. Acute hand or wrist trauma, wrist trauma, first exam. Acute hand or wrist trauma, suspect acute scaphoid fracture, first exam, plus cast and repeat radiographs in 10-14 days. Acute hand or wrist trauma, suspect distal radio-ulnar joint subluxation. Acute hand or wrist trauma, suspect hook of the hamate fracture. Acute hand or wrist trauma, suspect metacarpal fracture or dislocation. Acute hand or wrist trauma, suspect phalangeal fracture or dislocation. Acute hand or wrist trauma, suspect thumb fracture or dislocation. Acute hand or wrist trauma, suspect gamekeeper injury (thumb MCP ulnar collateral ligament injury). Chronic wrist pain, first study obtained in-patients with chronic wrist pain with or without prior injury, no specific area of pain specified. The IW reports cumulative trauma to the hands. There is no acute trauma documented. Without the support of the documentation, the request for bilateral hand radiographs is not medically necessary.

**MRI of the bilateral wrists:** Upheld

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

**MAXIMUS guideline:** Decision not based on MTUS. Decision based on Non-MTUS Official Disability Guidelines, Forearm, Wrist and Hand: MRI.

**Decision rationale:** According the above referenced guidelines, an MRI is indicated for the following clinical presentations: Acute hand or wrist trauma, suspect acute distal radius fracture, radiographs normal, next procedure if immediate confirmation or exclusion of fracture is required. Acute hand or wrist trauma, suspect acute scaphoid fracture, radiographs normal, next procedure if immediate confirmation or exclusion of fracture is required. Acute hand or wrist trauma, suspect gamekeeper injury (thumb MCP ulnar collateral ligament injury). Chronic wrist pain, plain films normal, suspect soft tissue tumor. Chronic wrist pain, plain film normal or equivocal, suspect Kienböck's disease. It is unclear from the chart material if the IW has previously had x-ray imaging and the results of these tests. The documentation does not reveal subjective or objective findings to support the above diagnosis. The records do not include thorough forearm or wrist examinations documented. There is no specific considered diagnoses discussed by the requesting provider. Without the support of the guidelines, the request for bilateral wrist MRIs 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 Forearm, Wrist and Hand Complaints 2004, Section(s): Diagnostic Criteria, Special Studies. Decision based on Non-MTUS Official Disability Guidelines, Electrodiagnostic studies.

**Decision rationale:** There are no reports from the prescribing physician, which adequately present neurologic findings leading to medical necessity for electrodiagnostic testing. Non-specific pain or paresthesia's are not an adequate basis for performance of EMG or NCV. Medical necessity for electrodiagnostic testing is established by a clinical presentation with a sufficient degree of neurologic signs and symptoms to warrant such tests. The MTUS, per the citations listed above, outlines specific indications for electrodiagnostic testing, and these indications are based on specific clinical findings. The physician should provide a diagnosis that is likely based on clinical findings, and reasons why the test is needed. The clinical evaluation is minimal and there is no specific neurological information showing the need for electrodiagnostic testing. Based on the recent clinical information, there are no neurologic abnormalities and no specific neurologic symptoms. According to the ODG guidelines, "Recommended as an option after closed fractures of distal radius & ulna if necessary to assess nerve injury. Also recommended for diagnosis and prognosis of traumatic nerve lesions or other nerve trauma." Electrodiagnostic testing includes testing for nerve conduction velocities (NCV), and possibly the addition of electromyography (EMG). Further guidelines state "Bilateral EMG is generally not necessary, but NCS may be necessary for comparison, depending on the results found on the affected side. If the NCS results are clearly abnormal, comparison is not necessary. If they are clearly normal, comparison is not necessary." Based on the current clinical information, bilateral electrodiagnostic testing is not medically necessary.

**EMG/NCV of the bilateral lower extremities:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Forearm, Wrist and Hand Complaints 2004, Section(s): Diagnostic Criteria, Special Studies. Decision based on Non-MTUS Official Disability Guidelines, EMG.

**Decision rationale:** Medical necessity for electrodiagnostic testing is established by a clinical presentation with a sufficient degree of neurologic signs and symptoms to warrant such tests. Non-specific, nondermatomal extremity symptoms are not sufficient alone to justify electrodiagnostic testing. The MTUS, per the citations listed above, outlines specific indications for electrodiagnostic testing, and these indications are based on specific clinical findings. The physician should provide a diagnosis that is likely based on clinical findings, and reasons why the test is needed. The clinical evaluation is minimal and there is no specific neurological information showing the need for electrodiagnostic testing. For example, a diagnosis of radiculopathy should be supported by the signs and symptoms listed in the MTUS cited above. ODG guidelines state "Recommended as an option (needle, not surface). EMGs (electromyography) 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." Based on the current clinical information, electrodiagnostic testing is not medically necessary.

**Physical therapy, 18 sessions for the cervical and lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009 Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009 Guidelines, Section(s): Physical Medicine.

**Decision rationale:** The CA MTUS Chronic Pain Medical Treatment Guidelines for manual therapy and manipulation are used in support of this decision. Documentation states the IW previously had physical therapy. It appears from the documentation this was several years previous and for the lumbar spine. The details of this therapy are not available for review. It is the assumed this request is for first time physical therapy evaluation and treatment of the cervical spine. Documentation does not support the IW has previously undergone such treatments. According to referenced guidelines, manual therapies are recommended for musculoskeletal conditions. Guidelines support a trial of 6 visits over 2 weeks with evidence of functional improvements. The request for 18 visits exceeds this recommendation. The request is not medically necessary.

**Chiropractic therapy, 18 sessions for the cervical and lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009 Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009 Guidelines, Section(s): Physical Medicine.

**Decision rationale:** The CA MTUS Chronic Pain Medical Treatment Guidelines for manual therapy and manipulation are used in support of this decision. It is the assumed this request is for first time chiropractor evaluation and treatment of the cervical and lumbar spine. Documentation does not support the IW has previously undergone such treatments. According to referenced guidelines, manual therapies are recommended for musculoskeletal conditions. Guidelines support a trial of 6 visits over 2 weeks with evidence of functional improvements. The request for 18 visits exceeds this recommendation. The request is not medically necessary.

**Acupuncture, 18 sessions for the cervical and lumbar spine:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment 2007.

**Decision rationale:** The prescription for acupuncture is evaluated in light of the MTUS recommendations for the current prescription is for an initial course. The prescription is for 18 visits, which exceeds the quantity recommended in the MTUS. As discussed in the MTUS, chronic pain section, the goal of all treatment for chronic pain is functional improvement, in part because chronic pain cannot be cured. An initial course of acupuncture is not medically necessary based on a prescription request for 18 visits exceed the quantity recommended in the MTUS.

**Shockwave therapy, 3 sessions for the bilateral wrists/hands:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on MTUS. Decision based on Non-MTUS National Library of Medicine: UpToDate: Extracorporeal shockwave Therapy http://www.ncbi.nlm.nih.gov/pubmed/21767905.

**Decision rationale:** The CA MTUS and ODG guidelines do not discuss this topic. There is little evidence to support the evidence of ECSWT for non-specific wrist pain. There is not good evidence supporting its use. The above reference guidelines states "Extracorporeal shock wave treatment (ESWT) has been effective in stimulating fracture healing, and it has been adopted as a therapy to restore vascular supply in those bone conditions characterized by vascular impairment." The records do not provide a diagnosis of vascular impairment or fracture. At this point in evaluation, there is no clear diagnosis for the bilateral wrist pain. As such, the request for bilateral wrist shockwave therapy is not medically necessary.

**Shockwave therapy, 6 sessions for the cervical, thoracic, lumbar spine:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on MTUS. Decision based on Non-MTUS Official Disability Guidelines, Shockwave: Low Back, Neck and Upper Back.

**Decision rationale:** The CA MTUS is silent on this topic. According to ODG guidelines, shockwave treatment is not recommended for back pain. The available evidence does not support the effectiveness of ultrasound or shock wave for treating back pain the absence of such evidence, the clinical use of these forms of treatment is not justified and should be discouraged. The IW has pain throughout her entire spine. It is unclear from the documentation what level the extracorporeal shock wave treatment was provided. As the treatments are not recommended for back pain, the request for shockwave treatments and special reports are not medically necessary.

**TENS Unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009 Guidelines.

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

**Decision rationale:** It is unclear from the request what the TENS unit is being requested to treat. The IW has multiple, body wide diagnoses. The CA MTUS ACOEM guidelines recommend against the use of TENS units for the management of low back complaints. Additionally, the chronic pain management guidelines recommend against this therapy as a primary treatment, but support a one-month home based trial. The request does not give a requested length of time for TENS unit trial. Given the incomplete request and unclear duration of treatment, the request for TENS patches are not medically necessary.

**Hot/Cold unit:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS General Approaches 2004 Guidelines, Section(s): Initial Approaches to Treatment, MTUS Chronic Pain Medical Treatment 2009 Guidelines, Section(s): Introduction.

**Decision rationale:** The request does not specify what body part the hot/cold unit is being prescribed to treat. Additionally, the request does not give direction to the frequency or duration of each therapy. The treating physician has not defined this device, if that is what it is, rather than a recommendation to use ice packs. There is no recommendation for any specific device in order to accomplish this. Heat and cold can be applied to the skin using simple home materials, e.g. ice and hot water, without any formal medical device or equipment. Per the above referenced ACOEM guideline, heat or cold may be used for two weeks or less. This patient's condition is long past the two-week duration. The updated ACOEM Guidelines for Chronic Pain are also cited. There may be some indication for cold therapy, but the recommendation is for home application of non-proprietary, low-tech, therapy in the context of functional restoration. There is no evidence of any current functional restoration program. The treating physician has not provided any information in support of the specific devices prescribed for this patient, and the nature of the requested device was not explained. The cold compression device prescribed for this injured worker is not medically necessary based on the MTUS, other guidelines, and lack of a sufficient treatment plan.

**Pain management referral for thoracic spine ESI consult:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009 Guidelines, Section(s): Epidural steroid injections (ESIs).

**Decision rationale:** The CA MTUS Chronic Pain Medical Treatment Guidelines recommends epidural injections when a patient has symptoms, physical examination findings, and radiographic or electrodiagnostic evidence to support a radiculopathy. There are no electrodiagnostic studies

included in the medical records provided. There are many kinds of injections, many of which lack good medical evidence. The treating physician will need to provide a more specific referral to allow for an adequate demonstration of medical necessity. The ACOEM Guidelines cited above recommend against trigger point injections, ligamentous injections, and facet joint injections, for example. Other kinds of injections are addressed in other guidelines. The MTUS for chronic pain states that epidural steroid injection is only for very specific radiculopathies shown by objective means. The IW has not had any conservative therapies to date. There has been little medications use and there has been no physical medicine treatments. As it stands now, there is not an adequate basis on which to refer this injured worker for an unspecified injection and the referral is therefore not medically necessary.