

<b>Case Number:</b>	CM15-0179664		
<b>Date Assigned:</b>	09/21/2015	<b>Date of Injury:</b>	12/30/2009
<b>Decision Date:</b>	11/13/2015	<b>UR Denial Date:</b>	08/27/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/11/2015

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to an expert reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. He/she has been in active clinical practice for more than five years and is currently working at least 24 hours a week in active practice. The expert reviewer was selected based on his/her clinical experience, education, background, and expertise in the same or similar specialties that evaluate and/or treat the medical condition and disputed items/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: 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:

The injured worker is a 48 year old male who sustained an industrial injury on 12-30-2009. According a progress report dated 08-20-2015, the injured worker reported lumbar, sacroiliac, left anterior shoulder, left clavicular, left posterior shoulder, left cervical dorsal, left and right cervical and right and left anterior and posterior hand pain. Current pain level was rated 5 on a scale of 10 being the worst and was noticeable approximately 90% of the time. Discomfort at its worst was rated 8 and at its best a 5. Numbness and tingling to right and left anterior hand, right and left anterior leg, right and left shin, right and left anterior knee, right and left ankle, right and left foot, right and left posterior leg, right and left posterior knee, right and left calf and right foot pain was noticed at approximately 40% of the time. Other reported symptoms included dizziness, insomnia, anxiety and stress. Symptoms were made better with pain medications, rest and physical therapy and worse with walking, bending, lifting, carrying, climbing, turning and standing. Objective findings included palpable tenderness at left cervical dorsal, upper thoracic, right cervical dorsal, cervical, lumbar, left and right sacroiliac, sacral and left and right anterior wrist. The injured worker had severe difficulty changing from standing and seating position and required the use of a cane for mobility. Cervical range of motion was decreased. Positive Spurling's on the left was noted. Left shoulder range of motion was decreased. Positive impingement was noted on the left. Range of motion of the left wrist was decreased with flexion and extension. Lumbar range of motion was decreased. The treatment plan included a follow up appointment, acupuncture 2 x 3 for the cervical and lumbar spine, orthopedic evaluation for the left shoulder, electromyography (EMG), nerve conduction velocity (NCV) studies of the bilateral upper extremities, physical therapy 2 x 3 for the cervical and lumbar spine, topical analgesic cream and Norco. The injured

worker was temporarily totally disabled. On 08-27-2015, Utilization Review non-certified the request for Norco 10-325 mg #60, Flurbiprofen 20 Percent, Baclofen 2 Percent, Dexamethasone 2 Percent, Menthol 2 Percent, Camphor 2 Percent, Capsaicin .0375 Percent, Hyaluronic Acid .20 Percent 180 Grams, acupuncture 2 x 3, physical therapy 2 x 3, EMG of the bilateral upper extremities and NCV of the bilateral upper extremities and certified the request for follow up psychiatrist, ortho evaluation for the left shoulder and a follow up in 45 days.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Norco 10/325 MG #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): Opioids, criteria for use.

**Decision rationale:** The request is for the use of a medication in the opioid class. The MTUS guidelines state that for ongoing treatment with a pharmaceutical in this class, certain requirements are necessary. This includes not only adequate pain control, but also functional improvement. Four domains have been proposed for management of patients on opioids. This includes pain relief, side effects, physical and psychosocial functioning, and the occurrence of any potentially aberrant drug-related behaviors. In this case, there is inadequate documentation of persistent functional improvement seen. As such, the request is not certified and therefore not medically necessary. All opioid medications should be titrated down slowly in order to prevent a significant withdrawal syndrome.

**Flurbiprofen 20 Percent, Baclofen 2 Percent, Dexamethasone 2 Percent, Menthol 2 Percent, Camphor 2 Percent, Capsaicin .0375 Percent, Hyaluronic Acid .20 Percent 180 Grams:**  
Upheld

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

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

**Decision rationale:** The request is for the use of a compounded medication for topical use to aid in pain relief. These products contain multiple ingredients, which each have specific properties and mechanisms of action. The MTUS guidelines state the following: "Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended." In this case, the compounded topical treatment contains an NSAID. Qualifying factors for this product is indicated by the following per the guidelines: The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period. (Lin, 2004) (Bjordal, 2007) (Mason, 2004) When investigated specifically for osteoarthritis of the knee, topical NSAIDs have been shown to be superior to placebo for 4 to 12 weeks. Indications: Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other

joints that are amenable to topical treatment: Recommended for short-term use (4-12 weeks). There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. FDA-approved agents: Voltaren Gel 1% (Diclofenac): Indicated for relief of osteoarthritis pain in joints that lend themselves to topical treatment (ankle, elbow, foot, hand, knee, and wrist). It has not been evaluated for treatment of the spine, hip or shoulder. In this case, as stated above, the patient would not qualify for the use of a topical NSAID. This is based on the diagnosis and treatment duration. As such, the request is not medically necessary.

**Acupuncture 2x3:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck & upper back (acute & chronic)/Acupuncture.

**Decision rationale:** The request is for acupuncture of the neck. The official disability guidelines state the following regarding this topic: Under study for upper back, but not recommended for neck pain. Despite substantial increases in its popularity and use, the efficacy of acupuncture for chronic mechanical neck pain still remains unproven. Acupuncture reduces neck pain and produces a statistically, but not clinically, significant effect compared with placebo. The beneficial effects of acupuncture for pain may be due to both nonspecific and specific effects. (White, 2004) Acupuncture is superior to conventional massage, dry needling of local myofascial trigger points, and sham laser acupuncture, for improving active range of motion and pain in patients with chronic neck pain, especially in patients with myofascial pain syndrome. (Blossfeldt, 2004) (Konig, 2003) (Irnich, 2002) (Irnich, 2001) There is limited or conflicting evidence from clinical trials that acupuncture is superior to sham or active controls for relief of neck pain. There is moderate evidence that acupuncture is more effective than wait-list control for neck disorders with radicular symptoms. (Trinh, 2007) A recent study concluded that adequate acupuncture treatment may reduce chronic pain in the neck and shoulders and related headache, and the effect lasted for 3 years. (He, 2004) There is little information available from trials to support the use of many physical medicine modalities for mechanical neck pain, often employed based on anecdotal or case reports alone. In general, it would not be advisable to use these modalities beyond 2-3 weeks if signs of objective progress towards functional restoration are not demonstrated. (Kjellman, 1999) (Gross-Cochrane, 2002) (Aker, 1996) (Bigos, 1999) (Gross-Cochrane, 2004) (Birch, 2004) Another recent trial found that acupuncture is more effective than TENS placebo treatment. (Vas, 2006) This passive intervention should be an adjunct to active rehab efforts. For an overview of acupuncture and other conditions in which this modality is recommended see the Pain Chapter. ODG Acupuncture Guidelines: Initial trial of 3-4 visits over 2 weeks. With evidence of objective functional improvement, total of up to 8-12 visits over 4-6 weeks. (Note: The evidence is inconclusive for repeating this procedure beyond an initial short course of therapy.) In this case, this treatment modality is not indicated. As clearly stated above, due to poor scientific evidence of efficacy, acupuncture of the neck is not supported. As such, the request is not medically necessary.

**PT 2x3:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck/Physical therapy (PT).

**Decision rationale:** The request is for physical therapy. The official disability guidelines state the following regarding this topic: ODG Physical Therapy Guidelines Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home PT. Also, see other general guidelines that apply to all conditions under Physical Therapy in the ODG Preface, including assessment after a "six-visit clinical trial." Cervicalgia (neck pain); Cervical spondylosis (ICD9 723.1; 721.0): 9 visits over 8 weeks. Sprains and strains of neck (ICD9 847.0): 10 visits over 8 weeks. Displacement of cervical intervertebral disc (ICD9 722.0): Medical treatment: 10 visits over 8 weeks. Post-injection treatment: 1-2 visits over 1 week. Post-surgical treatment (discectomy/laminectomy): 16 visits over 8 weeks. Post-surgical treatment (fusion, after graft maturity): 24 visits over 16 weeks. Degeneration of cervical intervertebral disc (ICD9 722.4): 10-12 visits over 8 weeks. See 722.0 for post-surgical visits. Brachia neuritis or radiculitis NOS (ICD9 723.4): 12 visits over 10 weeks. See 722.0 for post-surgical visits. Post Laminectomy Syndrome (ICD9 722.8): 10 visits over 6 weeks. Fracture of vertebral column without spinal cord injury (ICD9 805): Medical treatment: 8 visits over 10 weeks. Post-surgical treatment: 34 visits over 16 weeks. Fracture of vertebral column with spinal cord injury (ICD9 806): Medical treatment: 8 visits over 10 weeks. Post-surgical treatment: 48 visits over 18 weeks. Work conditioning (See also Procedure Summary entry): 10 visits over 4 weeks. In this case, the number of requested treatments is not supported by the guidelines. As stated, a "six-visit clinical trial" is indicated with continued therapy depending on the diagnosis. There is documentation that the patient has received physical therapy in the past, but no records indicate pain and functional benefit which is required for further treatments. As such, the request is not medically necessary.

**EMG BUE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies, and Forearm, Wrist, and Hand Complaints 2004, Section(s): Diagnostic Criteria, and Low Back Complaints 2004.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and upper back/EMGs (electromyography).

**Decision rationale:** Recommended (needle, not surface) as an option in selected cases. The American Association of Electrodiagnostic Medicine conducted a review on electrodiagnosis in relation to cervical radiculopathy and concluded that the test was moderately sensitive (50% - 71%) and highly specific (65%-85%). (AAEM, 1999) EMG findings may not be predictive of surgical outcome in cervical surgery, and patients may still benefit from surgery even in the absence of EMG findings of nerve root impingement. This is in stark contrast to the lumbar spine where EMG findings have been shown to be correlative with symptoms. Indications when particularly helpful: EMG may be helpful for patients with double crush phenomenon, in particular, when there is evidence of possible metabolic pathology such as neuropathy secondary to diabetes or thyroid disease, or evidence of peripheral compression such as carpal tunnel syndrome. In this case, the patient does not meet criteria for the study requested. This is secondary to poor documentation of planned surgical measures or how the results of this test will change the clinical management. Pending receipt of information further clarifying this, the study is not medically necessary.

**NCV BUE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Diagnostic Criteria. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back Chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and upper back/Nerve conduction studies.

**Decision rationale:** The request is for nerve conduction studies. The MTUS guidelines are silent regarding this issue. The ODG states the following: Not recommended to demonstrate radiculopathy if radiculopathy has already been clearly identified by EMG and obvious clinical signs, but recommended if the EMG is not clearly radiculopathy or clearly negative, or to differentiate radiculopathy from other neuropathies or non-neuropathic processes if other diagnoses may be likely based on the clinical exam. There is minimal justification for performing nerve conduction studies when a patient is already presumed to have symptoms on the basis of radiculopathy. (Utah, 2006) (Lin, 2013) While cervical electrodiagnostic studies are not necessary to demonstrate a cervical radiculopathy, they have been suggested to confirm a brachial plexus abnormality, diabetic neuropathy, or some problem other than a cervical radiculopathy, with caution that these studies can result in unnecessary over treatment. (Emad, 2010) (Plastaras, 2011) (Lo, 2011) (Fuglsang-Frederiksen, 2011) See also the Shoulder Chapter, where nerve conduction studies are recommended for the diagnosis of TOS (thoracic outlet syndrome). Also, see the Carpal Tunnel Syndrome Chapter for more details on NCS. Studies have not shown portable nerve conduction devices to be effective. In this case, the use of this diagnostic test is not supported. This is secondary to radiculopathy already being clearly identified based on clinical signs. As such, the request is not medically necessary.