

<b>Case Number:</b>	CM15-0038054		
<b>Date Assigned:</b>	04/02/2015	<b>Date of Injury:</b>	12/31/1969
<b>Decision Date:</b>	05/13/2015	<b>UR Denial Date:</b>	02/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/27/2015

### 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: California  
Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 32-year-old female who reported injury on 03/04/2011. The mechanism of injury was repetitive stress. Prior surgeries and diagnostics were stated to be none. The documentation of 01/15/2015 revealed the injured worker had x-rays of the right wrist and started physical therapy. The injured worker underwent chiropractic care. The subjective complaints included right elbow pain, wrist pain, and hand pain. The objective physical examination revealed right elbow tenderness to palpation laterally. There was a positive Cozen's test, and the injured worker had right wrist tenderness to palpation in the dorsal aspect. There were no x-rays taken. The diagnosis included right elbow sprain/strain, right elbow epicondylitis, right wrist sprain/strain, right wrist dorsal ganglion cyst. The treatment plan included tramadol 50 mg, compounded medications, topical medications, interferential unit, hot and cold unit, Fexmid, the Functional Capacity Evaluation to ensure the injured worker could safely meet the physical demands of her occupation, and physical therapy. There was a Request for Authorization submitted for review dated 02/12/2015. The documentation of 02/12/2015 revealed the injured worker was noted to have complaints of pain in the right elbow and numbness in the right wrist. The objective findings revealed grade 3 to 4 tenderness to palpation, which had increased from grade 3 on the last visit. The injured worker had grade 3 to 4 tenderness to palpation of the right wrist. The treatment plan included physical therapy 2 times a week x6 weeks, tramadol, cyclobenzaprine, topical medications, extracorporeal shockwave therapy for the elbow, EMG/NCV of the bilateral upper extremities, and urine toxicology screening. The physician documented topical medications were prescribed to minimize possible neurovascular complications and to avoid complications associated with the use of narcotic medications as well as upper GI bleeding from the use of NSAIDs.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **X-rays right shoulder QTY 1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 557-559.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209.

**Decision rationale:** The American College of Occupational and Environmental Medicine indicate that routine testing including plain film x-rays of the shoulder and more specialized imaging are not recommended during the first month to 6 weeks of activity limitation. The clinical documentation submitted for review failed to provide documentation of a failure of conservative care. The rationale for the request of the x-ray was not provided. There were no objective findings upon physical examination to support the necessity for right shoulder x-ray. Given the above, the request for x-rays right shoulder quantity 1 is not medically necessary.

### **EMG/NCV bilateral lower extremities QTY 1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM. Decision based on Non- MTUS Citation Official Disability Guidelines (ODG); Online, electro diagnostic testing.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Nerve conduction studies (NCS).

**Decision rationale:** The American College of Occupational and Environmental Medicine states that Electromyography (EMG), including H reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. They do not address NCS of the lower extremities. As such, secondary guidelines were sought. The Official Disability Guidelines do not recommend NCS as there is minimal justification for performing nerve conduction studies when an injured worker is presumed to have symptoms on the basis of radiculopathy. There was a lack of documentation of objective findings upon physical examination to support the necessity for bilateral lower extremity testing. There is no documentation of peripheral neuropathy condition that exists in the bilateral lower extremities. There is no documentation specifically indicating the necessity for both an EMG and NCV. The clinical documentation submitted for review failed to provide documentation of exceptional factors. There was a lack of documented rationale for the request. Given the above, the request for EMG/NCV bilateral lower extremities is not medically necessary.

### **Functional Capacity Evaluation QTY 1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 137 and 138.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness for Duty Chapter, FCE.

**Decision rationale:** The American College of Occupational and Environmental Medicine guidelines indicate there is a functional assessment tool available and that is a Functional Capacity Evaluation, however, it does not address the criteria. As such, secondary guidelines were sought. The Official Disability Guidelines indicates that a Functional Capacity Evaluation is appropriate when a worker has had prior unsuccessful attempts to return to work, has conflicting medical reports, the injured worker had an injury that required a detailed exploration of a workers abilities, a worker is close to maximum medical improvement and/or additional or secondary conditions have been clarified. The documentation indicated the rationale was to ensure the injured worker could return to work safely. However, there was a lack of documentation indicating the injured worker had an unsuccessful attempt to return to work.

Given the above, the request for Functional Capacity Evaluation is not medically necessary.

### **Lumbosacral Brace QTY 1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 9 and 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Low Back (acute & chronic) (updated 3/31/14).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

**Decision rationale:** The American College of Occupational and Environmental Medicine Guidelines indicate that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptomatic relief. Additionally, the continued use of a back brace could lead to deconditioning of the spinal muscles. There was a lack of documentation indicating the injured worker had spinal instability. There was a lack of documented rationale for the request. Given the above, the request for lumbosacral brace quantity 1 is not medically necessary.

### **Interferential Unit QTY 1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 141-121.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118.

**Decision rationale:** The California Medical Treatment Utilization Schedule guidelines do not recommend interferential current stimulation (ICS) as an isolated intervention and it should be used with recommended treatments including work, and exercise. There was a lack of documentation indicating the injured worker would utilize the interferential unit with exercise. Additionally, the request as submitted failed to indicate whether the unit was for rental or purchase and failed to indicate the duration of use and the body part to be treated. Given the above, the request for interferential unit quantity 1 is not medically necessary.

### **Hot & Cold Unit QTY 1: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Compensation 2012, Work Loss Data Institute; ODG cold/heat packs.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 201-205.

**Decision rationale:** The American College of Occupational and Environmental Medicine indicate that at home local applications of cold are appropriate during the first few days of acute complaints and thereafter heat application. The clinical documentation submitted for review failed to provide documentation the injured worker could not apply heat packs or cold packs at home. There was a lack of documentation indicating a necessity for a hot and cold unit. The request as submitted failed to indicate the body part to be treated and failed to indicate whether the unit was for rental or purchase. Given the above, the request for hot and cold unit quantity 1 is not medically necessary.

**Physical Therapy QTY 12:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 98 and 99, Chronic Pain Treatment Guidelines Functional Improvement measures Page(s): 48.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98, 99.

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines recommend physical medicine for up to 10 visits of myalgia, myositis, and radiculitis. The clinical documentation submitted for review indicated the injured worker had previously undergone physical medicine treatment. There was a lack of documentation of objective functional improvement that was received, and the quantity of sessions attended. There was a lack of documentation of remaining objective functional deficits. The request as submitted failed to indicate the body part to be treated with physical therapy. Given the above, the request for physical therapy quantity 12 is not medically necessary.

**Medications compounds QTY 1:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Compensation 2012 on the web, Work Loss Data Institute, medications-compound.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines indicate topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. The clinical documentation submitted for review indicated the injured worker had utilized topical compounds. The efficacy was not provided. The request as submitted failed to indicate the specific components and percentages for the topical compounds. There was a lack of documentation indicating the body part and the frequency. Given the above, and the lack of documentation, the request for medication compounds quantity 1 is not medically necessary. Additionally, specific guidelines could not be applied as per the submitted request, the compounds were not provided.

**Tramadol 50mg #40: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram, Ultram ER, generic available in immediate release) Page(s): 93, 94 and 113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications for Chronic pain, ongoing management Page(s): 60, 78.

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines recommend opioids for the treatment of chronic pain. There should be documentation of objective functional improvement, an objective decrease in pain, and documentation the injured worker is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review indicated the injured worker was being monitored for aberrant drug behavior through urine drug screens. There was a lack of documentation of objective functional improvement and an objective decrease in pain. The request submitted failed to indicate the frequency for the requested medication. There was a lack of documentation indicating the injured worker was being monitored for adverse side effects. Given the above, the request for tramadol 50 mg #40 is not medically necessary.

**Cyclobenzaprine 7.5mg #50: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain) Page(s): 64-66.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines recommend muscle relaxants as a second line option for short term treatment of acute low back pain. Their use is recommended for less than 3 weeks. There should be documentation of objective functional improvement. The clinical documentation submitted for review indicated the injured worker had utilized the medication for an extended duration of time. There was a lack of documentation of objective functional improvement. The request as submitted failed to indicate the frequency for the requested medication. Given the above, the request for cyclobenzaprine 7.5 mg #50 is not medically necessary.