

<b>Case Number:</b>	CM15-0091459		
<b>Date Assigned:</b>	05/21/2015	<b>Date of Injury:</b>	08/30/2012
<b>Decision Date:</b>	10/02/2015	<b>UR Denial Date:</b>	04/07/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/12/2015

### HOW THE IMR FINAL DETERMINATION WAS MADE

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

The Expert Reviewer has the following credentials:

State(s) of Licensure: Texas, Florida

Certification(s)/Specialty: Anesthesiology, Pain Management

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

The 50-year-old female injured worker suffered an industrial injury on 08/30/2012. The diagnoses included cervical and lumbar disc herniations, lumbosacral radiculitis, right shoulder sprain/strain, left carpal tunnel syndrome, bilateral wrist tendinitis, insomnia, anxiety disorder, cognitive difficulties and depression. The diagnostics included cervical magnetic resonance imaging. The injured worker had been treated with medications. On 3/12/2015 the treating provider reported complained of constant pain in the right had rated 7/10 along with numbness and tingling in the small finger. She reports that the pain is worsening. The neck had constant pain rated 6 to 7/10 and that the pain is worsening along with traveling to the shoulder. The neck pain traveled to the back of the head. The upper back had constant pain rated 7 to 8/10. The lower back pain rated 6/10 with numbness and tingling in the legs there were objective findings of tenderness in the cervical and lumbar paraspinal areas, positive straight leg raising tests and positive cervical neuroforamina compression test. The treatment plan included Tramadol 8%/Gabapentin 10%/Menthol 2%/Camphor 2%, Flurbiprofen 20%, Physical therapy, Acupuncture, Shockwave therapy, MRI of the right shoulder, Psychological evaluation and treatment, Internal medicine consultation and treatment, Sleep study, MRI of the cervical spine and MRI of the lumbar spine.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Transdermal Analgesic: Tramadol 8%, Gabapentin 10%, Menthol 2%, Camphor 2%:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Topical Analgesics.

**Decision rationale:** The CA MTUS and the ODG guidelines recommend that topical analgesic products can be utilized for the treatment of localized neuropathic pain when standard first line orally administered anticonvulsant and antidepressant medications have failed. The records did not show subjective and objective findings that is consistent with localized neuropathic pain such as CRPS. The guidelines recommend that topical medications be utilized individually to evaluate efficacy. There is lack of guidelines support to the utilization of topical formulations of tramadol, gabapentin, menthol and camphor for the treatment of chronic musculoskeletal pain. The criteria for transdermal analgesic: tramadol 8%, gabapentin 10%, menthol 2%, camphor 2% was not met. Therefore, the request is not medically necessary.

**Transdermal Analgesic: Flurbiprofen 20%:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-73. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, NSAIDs.

**Decision rationale:** The CA MTUS and the ODG guidelines recommend that topical analgesic products can be utilized for the treatment of localized neuropathic pain when standard first line orally administered anticonvulsant and antidepressant medications have failed. The records did not show subjective and objective findings that is consistent with localized neuropathic pain such as CRPS. The guidelines recommend that topical medications be utilized individually to evaluate efficacy. The utilization of topical formulations of NSAIDs is associated with development of tolerance and decreased efficacy. The records did not show that the patient had failed or was intolerant of orally administered NSAIDs. The criteria for the use of transdermal analgesic: flurbiprofen 20% was not met. Therefore, the request is not medically necessary.

**Physical Therapy for the Cervical Spine, Right Shoulder and Right Knee (12-sessions, 2 times a week for 6 weeks):** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Exercise, Physical Medicine Page(s): 46-47, 96-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter.

**Decision rationale:** The CA MTUS and the ODG guidelines recommend that physical therapy (PT) can be utilized for the treatment of exacerbation of musculoskeletal pain. The utilization of PT can be associated pain relief, reduction of analgesic utilization and functional restoration. The presence of significant psychiatric disorders can be associated with decreased compliance and efficacy of pain management treatment measures. The records indicate that the patient had previously completed physical treatment measures and medications management. The guidelines recommend that patients proceed to a home exercise program after completion of supervised physical treatments, the criteria for physical therapy for the cervical spine, right shoulder and right knee was not met. Therefore, the request is not medically necessary.

**Acupuncture for the Lumbar Spine (6-sessions, once a week for 6-weeks):** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Acupuncture.

**Decision rationale:** The CA MTUS and the ODG guidelines recommend that Acupuncture can be utilized for the treatment of exacerbation of musculoskeletal pain. The utilization of acupuncture can be associated pain relief, reduction of analgesic utilization and functional restoration. The presence of significant psychiatric disorders can be associated with decreased compliance and efficacy of pain management treatment measures. The records indicate that the patient had previously completed physical treatment measures and medications management but had not done acupuncture treatments. The criteria for Acupuncture for the Lumbar Spine was met. Therefore, the request is medically necessary.

**Shockwave Therapy to the Bilateral Wrists (3-sessions, once a week for 3-weeks):** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Blue Cross Blue Shield of Alabama.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Upper Extremities.

**Decision rationale:** The CA MTUS and the ODG guidelines recommend that physical treatments such as shockwave can be utilized for the treatment of exacerbation of musculoskeletal pain. The utilization of shockwave can be associated pain relief, reduction of analgesic utilization and functional restoration. The presence of significant psychiatric disorders can be associated with decreased compliance and efficacy of pain management treatment measures. The records indicate that the patient had previously completed physical treatment measures and medications management. The guidelines recommend that patients proceed to a home exercise program after completion of supervised physical treatments. The criteria for shockwave therapy to the bilateral wrists was not met. Therefore, the request is not medically necessary.

### **MRI of the Right Shoulder: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 202.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 561-563. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Shoulder.

**Decision rationale:** The CA MTUS and the ODG guidelines recommend that MRI can be utilized for the evaluation of deteriorating musculoskeletal conditions or neurological deficits when clinical examination and plain radiography are inconclusive. The MRI test is also utilized for the evaluation of a red flag condition. The records did not show that clinical evaluations and plain radiographs are inconclusive. There was no documentation of progressive neurological deficit or a red flag condition. The criteria for MRI of the right shoulder was not met. Therefore, the request is not medically necessary.

### **Psychological Evaluation and Treatment: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Psychological evaluations Page(s): 100-101.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 87-127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter.

**Decision rationale:** The CA MTUS and the ODG guidelines recommend that patients can be referred to a Specialist when the diagnosis is too complex or in the presence of significant co-existing psychiatric disorders. The presence of psychiatric disorders can be associated with decreased efficacy and compliance to pain treatment programs. The records indicate that the patient had significant psychosomatic disorders and insomnia. There is lack of functional restoration with various treatment programs. The criteria for the psychological evaluation and treatment was met. Therefore, the request is not medically necessary.

### **Internal Medicine Consultation and Treatment: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 87-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter.

**Decision rationale:** The CA MTUS and the ODG guidelines recommend that patients can be referred to the Specialist when the diagnosis is too complex or the presence of significant co-existing psychiatric disorders. The presence of psychiatric disorders can be associated with decreased efficacy and compliance to pain treatment programs. The records indicate that the patient had significant psychosomatic disorders and insomnia. There is lack of functional restoration with various treatment programs. The records did not show significant medical conditions that did not respond to standard treatment measures. The criteria for the Internal

Medicine Consultation and treatment was not met. Therefore, the request is not medically necessary.

**Sleep study:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 87-128. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter.

**Decision rationale:** The CA MTUS and the ODG guidelines recommend that patients can be referred the Specialist when the diagnosis is too complex or the presence of significant co-existing psychiatric disorders. The presence of psychiatric disorders can be associated with decreased efficacy and compliance to pain treatment programs. The records indicate that the patient had significant sleep dysfunction that did not resolve with medications management of sleep hygiene measures. There is lack of functional restoration with various treatment programs. The criteria for the sleep studies was met. Therefore, the request is medically necessary.

**MRI of the Cervical Spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 172.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 165-188. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Neck and Upper Back.

**Decision rationale:** The CA MTUS and the ODG guidelines recommend that MRI can be utilized for the evaluation of deteriorating musculoskeletal conditions or neurological deficits when clinical examination and plain radiography are inconclusive. The MRI test is also utilized for the evaluation of a red flag condition associated with chronic neck pain. The records did not show that clinical evaluations and plain radiographs are inconclusive. There was no documentation of progressive neurological deficit or a red flag condition. The criteria for MRI of the cervical spine was not met. Therefore, the request is not medically necessary.

**MRI of the Lumbar Spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303- 315. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Low Back.

**Decision rationale:** The CA MTUS and the ODG guidelines recommend that MRI can be utilized for the evaluation of deteriorating musculoskeletal conditions or neurological deficits when clinical examination and plain radiography are inconclusive. The MRI test is also utilized for the evaluation of a red flag condition associated with chronic low back pain. The records did not show that clinical evaluations and plain radiographs are inconclusive. There was no

documentation of progressive neurological deficit or a red flag condition. The criteria for MRI of the lumbar spine was not met. Therefore, the request is not medically necessary.