

<b>Case Number:</b>	CM15-0093235		
<b>Date Assigned:</b>	05/20/2015	<b>Date of Injury:</b>	08/05/1998
<b>Decision Date:</b>	09/22/2015	<b>UR Denial Date:</b>	04/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/14/2015

### 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, Arizona  
 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 50 year old, female who sustained a work related injury on 8/5/98. The diagnoses have included brachial neuritis/radiculitis, pain in limb, headache, lumbosacral neuritis/radiculitis and gastritis. Treatments have included medications, radiofrequency ablation left medial branch lumbar spine, facet joint injections, facet nerve blocks, and right knee injections. In the Neurosurgery/neurology Progress Report Primary Treating Physician dated 2/10/15, the injured worker complains of severe abdominal pain. She complains of headaches. She complains of pain in both knees, with increased pain in right knee. She also complains of pain in both shoulders, right worse than left. She has severe occipital tenderness. She is very tender in left sacroiliac joint. She has straight leg raises to 20 degrees in both legs. The treatment plan includes requests for a shower chair, a special orthopedic mattress and a motorized wheelchair. She needs placement in a detoxification program. She needs a 2nd opinion orthopedic consultation. It is recommended she get occipital block injections for headache control. It is recommended she start shockwave treatments to shoulders and knees. She needs to be evaluated as soon as possible by a gastroenterologist. Requests also made for refills of medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cyclobenzaprine 7.5mg #60: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-66.

**Decision rationale:** CA MTUS Chronic Pain Treatment Guidelines note that long-term use of muscle relaxants is not recommended. It is associated with mental and physical impaired abilities and has limited efficacy. The injured worker is still in pain, and long-term use of muscle relaxants is not recommended. It is made clear why long-term use is indicated for this drug; what functional and/or objective benefit the injured worker has received, or if pain has significantly improved with this agent. Medical necessity has not yet been substantiated. The request is not medically necessary.

**Gabapentin 30mg #120: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-epileptics for chronic pain Page(s): 16-21.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines state that anti-epilepsy drugs are recommended for neuropathic pain. They go on to state that a good outcome is defined as 50 percent reduction in pain and a moderate response is defined as 30 percent reduction in pain. There should be documentation of pain relief, and improvement in function as well as documentation of side effects incurred with use. The continued use of AEDs depends on improved outcomes versus tolerability of adverse effects. There is no mention within the submitted documentation to warrant certification of this request. Also, frequency was not mentioned and as such, this request is not medically necessary.

**Shockwave Therapy: Bilateral Shoulder/Bilateral Knee: 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 Official Disability Guidelines (ODG) ESWT.

**Decision rationale:** Per guideline criteria, there is no high grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction, heat/cold applications, massage, diathermy, cutaneous laser treatment, ultrasound, TENS units, and biofeedback. These palliative tools may be used on a trial basis but should be monitored closely. The ODG note that extracorporeal shock wave therapy is recommended for patients whose pain from calcifying tendinitis of the shoulder has remained despite six months of

standard treatment. The ODG states ESWT is not recommended for the lumbar spine, and the CA MTUS do not discuss ESWT for the cervical or lumbar spine. There is no mention of calcific tendinitis within the submitted documentation, and ESWT is not recommended for knee disorders. As such, this request is not medically necessary.

**Cognitive Study:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Cognitive Behavioral Therapy Page(s): 23.

**Decision rationale:** CA MTUS Chronic Pain 2009 Guidelines support cognitive behavioral therapy for patients at risk for delayed recovery. CA MTUS recommends allowing for initial 3 to 4 psychotherapy visits over two weeks. With evidence of objective functional improvement, a total of up to 6 to 10 visits over 5 to 6 weeks may be appropriate. Without clarifying the exact number of visits requested, including duration and frequency, the request is not medically necessary.

**Occipital Block Injections:** Overturned

**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 Official Disability Guidelines (ODG) Neck and Upper Back, Greater Occipital Nerve Block.

**Decision rationale:** According to the ODG, greater occipital nerve blocks are currently under study for use in treating occipital neuralgia and cervicogenic headaches. The injured worker is noted to have headaches related to chronic neck pain. A single occipital nerve block is indicated with further treatments pending the efficacy of the first. The request is medically necessary.

**Left Sacroiliac Joint Block:** 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 Official Disability Guidelines (ODG) Hip and Pelvis Chapter, Sacroiliac Joint Injection.

**Decision rationale:** According to the ODG, SI joint injections are an option if a patient has 3 positive exam findings for SI joint syndrome; diagnostic evaluation have addressed other

possible pain generators; at least 4-6 weeks of aggressive conservative therapy, including physical therapy, home exercises, and medication management. There is no mention of SI joint syndrome confirmed by 3 positive special tests. Necessity has not yet been substantiated. The request is not medically necessary.

**Gastrointestinal Consult:** Overturned

**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 ACOEM Practice Guidelines, Independent Medical Examinations and Consultations, Chapter 7, Page 127.

**Decision rationale:** According to the ACOEM, red flags are a reason for specialty consultation. In this case, the injured worker had severe abdominal pain and as a result, a GI specialist would be helpful for added expertise. This request is supported. The request is medically necessary.

**Detox program:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Detoxification Page(s): 42.

**Decision rationale:** California MTUS supports detoxification for indications including intolerable side effects, lack of response, aberrant drug behaviors as related to abuse and dependence, refractory co-morbid psychiatric illness, or lack of functional improvement. Within the submitted documentation, the injured worker is noted to have chronic pain, unremitting, without functional improvement and as a result, this meets guideline criteria for detoxification. The request is medically necessary.

**Functional Capacity Evaluation:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92.

**Decision rationale:** The California MTUS/ACOEM Practice Guidelines state a number of functional assessment tools are available, including functional capacity evaluations (FCE) when re-assessing function and functional recovery. The ODG do not recommend proceeding with an FCE if the sole purpose is to determine a worker's effort or compliance and/or if the worker has returned to work without having an ergonomic assessment arranged. There should be mention of a previous failure to return to work, or documentation of conflicting medical reporting

on precautions and/or fitness for modified duty work. There is no clear rationale as to why the injured worker needs a FCE. Without clarification, this request cannot at this time be supported. The request is not medically necessary.

**Anatomical Rating:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation Page(s): 33.

**Decision rationale:** According to the ACOEM, anatomical rating can be performed as part of a standard physical examination. Within the submitted documentation, there is no mention of why a separate anatomical rating is necessary and cannot be completed as part of the standard history and physical examination. Clarification is needed before necessity can be substantiated. The request is not medically necessary.