Case Number:	CM16-0234464		
Date Assigned:	12/16/2016	Date of Injury:	10/14/2016
Decision Date:	01/20/2017	UR Denial Date:	11/08/2016
Priority:	Standard	Application Received:	12/06/2016

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,Missouri,Mississippi
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:

This case involves a now 33-year-old male with a history of an occupational claim from 10/14/ 2016. The mechanism of injury is detailed as smashing the hand on a door. The current diagnoses are documented as work related fall, blunt head trauma with headaches, cervical spine strain with radicular complaints, thoracic spine strain/bilateral parascapular strain, right hand contusion/laceration, and lumbar spine strain. On 11/30/2016, the patient presented for a follow up visit. The patient complained of headaches with short term memory impact. The patient complained of intermittent moderate neck pain that radiated into the arms bilaterally. The patient also complained of intermittent moderate right hand/wrist pain with associated numbness and tingling rated 7/10 to 8/10. The patient also complained of intermittent moderate low back pain that radiated into the bilateral legs. Current medications included Ambien 10 mg and Mobic. On physical examination, there was increased tone with associated tenderness over the paracervical and trapezius muscles. There was guarding noted on the cervical examination. The patient had decreased range of motion of the cervical spine. Sensation to light touch and pinprick were intact from C3-T1 dermatomes bilaterally. The manual motor testing demonstrated no focal deficits in the C5-T1 myotomes. The patient had tenderness to palpation over the anterolateral shoulder and supraspinatus. There was restricted range of motion due to complaints of discomfort and pain. There was also rotator cuff weakness noted. The patient had a 0.5 cm healed incision over the dorsion of the second metacarpal neck that was hyperpigmented with keloid formation. There was also diffuse tenderness over the right wrist/hand. The range of motion of the bilateral wrist/hand was full. The treatment plan consisted of an MRI of the cervical spine, an MRI of the

lumbar spine, an MRI of the right hand, diclofenac, cyclobenzaprine, and lidocaine ointment. The Request for Authorization was signed on 10/28/2016. The prior determination on 11/25/2016 denied the request for the MRI of the cervical spine due to no specific findings of nerve compromise. The request for the MRI of the hand and wrist were previously denied due to lack of documentation of a specific disorder that would need the requested imaging. The request for diclofenac was previously denied due to a lack of documentation of any previous nonprescription medications. The request for cyclobenzaprine was previously denied due to guideline recommend for short term treatment. The request for lidocaine ointment was previously denied due to a lack of neuropathic pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Single positional MRI of the cervical spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies.

Decision rationale: The ACOEM Guidelines state that unequivocal objective findings that identify specific nerve compromise on neurological examination are sufficient evidence to warrant imaging studies if symptoms persist. On 11/30/2016, there was a lack of significant neurological deficits in the upper extremities that would support the usage of the MRI of the cervical spine. It is also unclear what recent conservative care the patient has tried and failed. Given the above, this request is not medically necessary.

Single positional MRI of the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies, Diagnostic Criteria.

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

Decision rationale: The ACOEM Guidelines state that unequivocal objective findings that identify specific nerve compromise on neurological examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and would consider surgery an option. There was no indication the patient was a candidate for surgery. In addition, on the clinical note dated 11/30/2016, there was a lack of documentation of neurological deficits in the lower extremities that would support the usage of an MRI. In addition, it is unclear what recent conservative care the patient has tried and failed. Given the above, this request is not medically necessary.

Single positional MRI of the right hand: Upheld

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

MAXIMUS guideline: Decision based on MTUS Forearm, Wrist, and Hand Complaints 2004, Section(s): Special Studies.

Decision rationale: The ACOEM Guidelines state that special studies are not needed until after a 4 to 6 week period of conservative care and observation. There was a lack of documentation of what recent conservative care the patient has tried and failed. Therefore, the requested imaging would not be supported. As such, the request is not medically necessary.

Diclofenac ER 100mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Initial Care, and Shoulder Complaints 2004, Section(s): Initial Care, and Low Back Complaints 2004, Section(s): Initial Care, Physical Methods.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2016, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

Decision rationale: The California MTUS 2016 Chronic Pain Guidelines state that NSAIDs are recommended as an option for short term symptomatic relief. The documentation submitted for review indicated that the patient utilized Mobic. The rational as to why the patient would require an additional NSAID drug is not apparent. Therefore, the requested Diclofenac ER 100mg #60 is not seen as medically necessary.

Cyclobenzaprine 7.5mg #90 was the original request. Cyclobenzaprine 7.5mg #63 was authorized by the Claims Administrator. The remaining IMR eligible portion of the original request, Cyclobenzaprine 7.5mg #27 is: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2016, Section(s): Cyclobenzaprine (Flexeril).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2016, Section(s): Cyclobenzaprine (Flexeril).

Decision rationale: The California MTUS 2016 Chronic Pain Guidelines state that cyclobenzaprine is recommended as an option, using a short course of therapy. The treatment should be brief. The medication is not recommended for longer than 2 to 3 weeks. The documentation submitted for review indicated that the patient utilized cyclobenzaprine since 10/14/2016. Given that the guidelines limit the use to 2 to 3 weeks, the ongoing usage would not be supported. In addition, on 11/30/2016, there was a lack of documentation regarding the patient's objective response to the prior usage of the medication including a quantified decrease in pain and objective increase in function. Given the above, this request is not medically necessary.

Lidocaine ointment 5% 106.32gm: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2016, Section(s): Topical analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2016, Section(s): Topical analgesics.

Decision rationale: The California MTUS 2016 Chronic Pain Guidelines state that topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety and are primarily recommended for neuropathic pain when trials of anti-depressants and anticonvulsants have failed. The guidelines also state that any compounded product that contains at least 1 drug or drug class is not recommended. There was no indication that the patient was intolerant to oral medication. It is also unclear of the rationale as to why the patient would require a topical cream versus oral medication. The guidelines also state that there are no other commercially approved topical formulations of lidocaine whether creams, gels, or lotions are indicated for neuropathic pain other than the brand name Lidoderm patch. Given that the requested service is an ointment, its usage is not supported. As such, the request is not medically necessary.