

<b>Case Number:</b>	CM13-0008991		
<b>Date Assigned:</b>	09/12/2013	<b>Date of Injury:</b>	05/13/2005
<b>Decision Date:</b>	03/11/2014	<b>UR Denial Date:</b>	07/26/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/09/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Georgia. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 enrollee is a 36-year-old male presenting with low back pain following a work-related injury on May 13, 2005. The claimant reports that the pain radiates from his low back along the right side. The claimant has tried medications including Vicodin, baclofen, and Nucynta. The physical exam was significant for axial back pain with the right greater than the left with extension greater than right rotation, symptoms of facetogenic greater than discogenic pain. MRI of the lumbar spine was significant for mild bilateral lateral recess stenosis without central canal or neural foraminal stenosis at L5-S1 secondary to a 5 mm disc protrusion. The claimant was diagnosed with degeneration of lumbar or lumbosacral intervertebral discs.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**IF (Interferential)/transcutaneous electrical nerve stimulation (TENS): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-121.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ICS Page(s): 118. Decision based on Non-MTUS Citation Hampp, Christian et al., Use of Prescription Anti-Obesity Drugs in the United States Pharmacotherapy: The Journal of Human Pharmacology and Drug Therapy, 2013; 33(12): 1299-1307

**Decision rationale:** The Physician Reviewer's decision rationale: Phentermine (Pharmacotherapy, 2013) is an amphetamine and the FDA approved indication is to serve as an adjunct to a reduced-calorie diet and increased physical activity for chronic weight management in adults with an initial body mass index of 30 kg/m<sup>2</sup> or greater (obese) or 27 kg/m<sup>2</sup> or greater (overweight) in the presence of at least one weight-related comorbid condition (e.g. hypertension, dyslipidemia, type 2 diabetes); however, according to the authors of the journal article, despite the indication of short-term use for amphetamine congeners, duration of use was similar to other anti-obesity drugs. Nevertheless, the reasons for and implications of the limited duration of use observed with all prescription anti-obesity drugs deserve further investigation. In regards to the case, the provider prescribed phentermine; however other than being noted that that the claimant was paying for this medication on his own there was no indication for the prescription. The provider did not indicate if this medication was being prescribed for the FDA approved weight loss or for off label-use. Ca MTUS does not make a statement on this particular medication but overall it does not recognize medications used for off-label use. Phentermine, is not medically necessary because FDA approved indications are not met.

**Chiropractic, quantity 1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-299.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy Page(s): 58.

**Decision rationale:** The Physician Reviewer's decision rationale: Per MTUS, chiropractor care is grouped with manual therapy & manipulation. This therapy is recommended for chronic pain caused by musculoskeletal conditions. Manual therapy as well as the use in the treatment of muscular skeletal pain. The intended goal or effect of manual medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in the patient's therapeutic exercise program and return to productive activities. Manipulation is manual therapy that moves a joint beyond the physiologic range of motion but not beyond the anatomic range of motion. For low back pain manual therapy is recommended as an option. Therapeutic care requires a trial of six visit over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Elective maintenance care is not medically necessary. For recurrences/flare-ups the need to reevaluate treatment success, if return to work achieved then 1-2 visits every 4-6 months. A request for one chiropractor visit does not meet MTUS guidelines. There was also lack of documentation for plan of return to work of the response to previous therapy if trialed in the past.

**Lumbar magnetic resonance imaging (MRI):** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Pain, pg. 303

**Decision rationale:** The Physician Reviewer's decision rationale: The ODG states that unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and would consider surgery an option. When the neurologic examination is less clear, however further physiologic evidence of nerve dysfunction should be obtained before entering an imaging study. Indiscriminate imaging will result in falls positive findings, suggests disc bulge, but are not the source of painful symptoms did not warrant surgery. If physiologic evidence indicates tissue consult for nerve impairment, the practitioner can discuss with a consultant the flexion of an imaging test to the find a potential cause (magnetic resonance imaging for neural or soft tissue, computed tomography for bony structures). The enrollee had a previous MRI with very mild findings. His physical exam also seemed very clear of its findings. There is no indication for another Lumbar MRI; therefore it is not medically necessary.

**Phentemine 37.5mg:** 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.

**Decision rationale:** The Physician Reviewer's decision rationale: MTG or ODG does not have a statement on Phentermine. There is no indication for this medication in chronic pain management; therefore Phentermine is not medically necessary.