

<b>Case Number:</b>	CM13-0039783		
<b>Date Assigned:</b>	02/10/2014	<b>Date of Injury:</b>	07/21/2013
<b>Decision Date:</b>	05/02/2014	<b>UR Denial Date:</b>	10/03/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/08/2013

### 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. The expert reviewer is Board Certified in Occupational Medicine, and is licensed to practice in California. 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/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 applicant is a represented [REDACTED] employee who has filed a claim for low back pain reportedly associated with an industrial injury of July 21, 2013. Thus far, the applicant has been treated with the following: Analgesic medications; attorney representation; transfer of care to and from various providers in various specialties; and extensive periods of time off of work. In a Utilization Review Report of October 2, 2013, the claims administrator denied request for various oral suspensions and topical compounds. The MTUS Chronic Pain Medical Treatment Guidelines were cited for many of the denials, although it did not appear that this was clearly a chronic pain case as of the date of the Utilization Review Report. The applicant's attorney subsequently appealed. A September 18, 2013 progress note is notable for comments that the applicant is a former delivery driver for [REDACTED]. The applicant was off of work, it was stated. Persistent low back pain was noted. The applicant had had six earlier sessions of physical therapy, it was stated, but nevertheless reported 8-9/10 low back pain. The applicant was reporting derivative psychological issues, including insomnia and depression. A diminished, 4/5 lower extremity strength was noted with slightly decreased sensorium noted about the left lower extremity at the L4 through S1 dermatome. Bilateral positive straight leg raising was noted. The applicant did exhibit a normal gait but had difficulty heel and toe walking secondary to pain. Several oral suspensions and topical compounds were endorsed while the applicant was placed off of work, on total temporary disability. It is incidentally noted that attending provider somewhat incongruously alluded to the applicant as both "he" and "she" in various sections of the report. MRI imaging and electrodiagnostic testing were also sought, along with a TENS unit. Also reviewed is an MRI of lumbar spine of September 27, 2013, largely negative, notable only for low-grade disk desiccation at L5-S1 without associated neurologic compromise.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **PRESCRIPTION FOR KETOPROFEN 20% IN PLO GEL 120GMS #1: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47, 49.

**Decision rationale:** As noted in the MTUS-adopted ACOEM Guidelines in Chapter 3, page 47, oral pharmaceuticals are a first-line palliative method. In this case, there was no evidence of intolerance to and/or failure of first-line oral pharmaceuticals so as to justify usage of topical agents and/or topical compounds such as the Ketoprofen containing gel proposed here, which are, per ACOEM Table 3-1 "not recommended." Therefore, the request is not certified, on Independent Medical Review. It is noted that this was not clearly a chronic pain case as of the date of the Utilization Review Report, July 21, 2013; therefore, ACOEM is invoked preferentially over the MTUS Chronic Pain Medical Treatment Guidelines.

### **PRESCRIPTION FOR SYNAPRYN 10MG/ML 500ML #1: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47, 49. Decision based on Non-MTUS Citation National Library of Medicine (NLM), Synapryn topic

**Decision rationale:** Again, the MTUS Guideline in ACOEM Chapter 3, page 47, deems oral pharmaceuticals the most appropriate first-line palliative method. In this case, there is no evidence of intolerance to and/or failure of first-line oral pharmaceuticals so as to justify usage of topical agents and/or topical compounds which are, per ACOEM Table 3-1 "not recommended." In this case, the attending has not proffered any applicant-specific rationale, narrative, or commentary along with the request for authorization so as to try and offset the unfavorable ACOEM recommendation. Therefore, the request is not certified, on Independent Medical Review.

### **PRESCRIPTION FOR TABRADOL 1MG/ML 250ML #1: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47, 49. Decision based on Non-MTUS Citation National Library of Medicine (NLM), Tabradol topic

**Decision rationale:** Tabradol is a cyclobenzaprine-containing suspension-compound. As noted in the MTUS-adopted ACOEM Guidelines in Chapter 3, Table 3-1, muscle relaxants such as cyclobenzaprine are "not recommended." In this case, the attending provider has not proffered any applicant-specific rationale, narrative, and/or commentary along with the request for authorization so as to try and offset the unfavorable ACOEM recommendation. The attending provider has not clearly stated why other analgesics do carry more favorable recommendations in ACOEM Table 3-1, such as acetaminophen and/or NSAIDs, cannot be employed here. Therefore, the request is likewise not certified, on Independent Medical Review.

**PRESCRIPTION FOR DEPRIZINE 15MG/ML ORAL SUSPENSION 250MGL #1:**  
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 National Library of Medicine, Ranitidine (Deprizine)

**Decision rationale:** The MTUS Chronic Pain Medical Treatment Guidelines were not applicable as of the date of the Utilization Review Report, October 2, 2013, as this was still a subacute injury as of that point in time. As noted by the National Library of Medicine (NLM), Deprizine or ranitidine is indicated in the treatment of heartburn, acid indigestion, gastroesophageal reflux disease, and/or stomach ulcers. In this case, however, the information on file does not establish the presence of any active issues with reflux, heartburn, dyspepsia, etc. for which ongoing usage of ranitidine or Deprizine would be indicated. There is no mention of dyspepsia made either in the body of the report or in the past medical history or review of systems section of the same. Accordingly, the request is not certified.

**PRESCRIPTION FOR DICOPANOL 5MG/ML 150ML #1:** 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 National Library of Medicine, DIPHENHYDRAMINE

**Decision rationale:** The MTUS does not address the topic. As noted by the National Library of Medicine (NLM), diphenhydramine or Dicopanor is an antihistamine can be employed in the treatment of Parkinson's disease, allergic reactions, and/or motion sickness. In this case, however, the information on file does not establish the presence of any of the aforementioned issues. There is no mention of any allergic reaction issues present on the progress report in question. Therefore, the request is likewise not certified, on Independent Medical Review.

**PRESCRIPTION FOR FANATREX 25MG/ML 420ML #1:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47. Decision based on Non-MTUS Citation National Library of Medicine, GABAPENTIN (FANATREX)

**Decision rationale:** The MTUS Chronic Pain Medical Treatment Guidelines were not applicable for the subacute nature of the applicant's complaints as of the date of the Utilization Review Report, October 2, 2013. As noted by the National Library of Medicine (NLM), Fanatrex or gabapentin can be employed to treat seizures, restless leg syndrome, and/or issues related to shingles or postherpetic neuralgia. In this case, the attending provider apparently dispensed Fanatrex as a compounded suspension of gabapentin and other proprietary ingredients, as he noted in his progress note. Again, as with the other drugs, the attending provider did not clearly state why first-line oral pharmaceuticals could not be employed here, as suggested by ACOEM Chapter 3, page 47. The rationale for usage of Fanatrex was, as with the other items, highly templated and do not provide any applicant-specific rationale. Accordingly, the request is likewise not certified, on Independent Medical Review.

**X-RAYS OF THE LUMBAR SPINE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303, 308.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

**Decision rationale:** As noted in the MTUS-adopted ACOEM Guidelines in Chapter 12, Table 12-8, page 309, routine usage of radiographs of the lumbar spine in the absence of red flags is "not recommended." In this case, the attending provider has not clearly stated what is suspected here. No clear diagnosis or differential diagnosis was proffered. It was not clearly stated why plain films of the lumbar spine were needed or indicated here, approximately two months plus removed from the date of injury. Accordingly, the request is likewise not certified, on Independent Medical Review.

**8 PHYSICAL THERAPY SESSIONS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 134.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299.

**Decision rationale:** Prior to transferring care to the current primary treating provider (PTP), a survey of the file suggested that the applicant had had earlier physical therapy, seemingly in excess of the one- to two-session course recommended in the MTUS-adopted ACOEM

Guidelines in Chapter 12, Table 12-5 for education, counseling, and evaluation of home exercise for range of motion and strengthening purposes. There was no evidence of functional improvement following completion of the same. The applicant remained highly reliant on various medications, physical therapy, and various oral and topical compounds. The applicant remained off of work, on total temporary disability. All of the above, taken together, implies the lack of functional improvement as defined in MTUS 9792.20f despite completion of prior unspecified amounts of physical therapy. Therefore, the request is not certified, on Independent Medical Review.

### **3 SHOCKWAVE THERAPY SESSIONS: 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), Low Back, Lumbar and Thoracic (Acute and Chronic).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Shock Wave Therapy topic

**Decision rationale:** While ACOEM does not specifically address the topic of extracorporeal shock wave therapy for the lumbar spine, ESWT is considered a form of ultrasound therapy which, per ACOEM Chapter 12, page 300, has "no proven efficacy" in treating acute low back symptoms. It is further noted that a non-MTUS Guideline, the ODG Low Back Chapter, Shock Wave Therapy topic states that extracorporeal shock wave therapy is "not recommended" as there is no evidence which would support the effectiveness of either ultrasound or shock wave for treating low back pain, as is present here. Therefore, the request is not certified owing to the unfavorable ACOEM and ODG recommendations.

### **MRI OF THE LUMBAR SPINE: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 303.

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

**Decision rationale:** As noted above, the MRI study in question was ultimately performed in September 27, 2013 and was essentially negative. As further noted in the MTUS-adopted ACOEM Guidelines in Chapter 12, page 303, unequivocal finding which identify specific neurologic compromise is sufficient evidence to warrant imaging studies in applicants who do not respond to treatment and who would consider surgery an option. Indiscriminate MRI imaging is not recommended, as it will often result in false-positive findings, such as disk bulges, which ACOEM notes do not necessarily warrant treatment and do not warrant surgery. In this case, the attending provider, in addition to pursuing MRI imaging, also sought various other conservative treatments, including physical therapy, acupuncture, shock wave therapy, etc. on the office visit in question. Thus, there is no clear indication or evidence that the applicant had in fact failed

conservative treatment before the MRI was sought. There is likewise no evidence that the applicant was actively considering or contemplating lumbar spine surgery. For all of the stated reasons, then, the request is not certified, on Independent Medical Review.

**FUNCTIONAL CAPACITY EVALUATION: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM OCCUPATIONAL MEDICINE PRACTICE GUIDELINES, 2ND EDITION, 2004, CHAPTER 7-INDEPENDENT MEDICAL EXAMINATIONS AND CONSULTATIONS,

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM PRACTICE GUIDELINES 2ND ED., INDEPENDENT MEDICAL EXAMINATIONS AND CONSULTATIONS CHAPTER, PGS. 137-138

**Decision rationale:** The MTUS Chronic Pain Medical Treatment Guidelines were not applicable for this subacute injury as of the date of the Utilization Review Report. Those portions of the MTUS-adopted ACOEM Guidelines do not necessarily address the need for functional capacity testing. However, as noted in the Chapter 7 ACOEM Guidelines on pages 137 and 138, FCE testing is overly used, widely promoted, and is not necessarily an accurate representation or characterization of what an applicant can or cannot do in the workplace. In this case, it is not clear why the FCE testing is being sought as the applicant is concurrently receiving other treatments such as physical therapy, acupuncture, etc. which is likely to result in some improvement in the applicant's clinical state. It is further noted that the applicant is off of work, on total temporary disability and may or may not have a job to return to or any clear return to work goal. It is not clear that the applicant is/was intent on returning to his former work at [REDACTED] as a driver. Accordingly, the request is likewise not certified.

**NERVE CONDUCTION VELOCITY STUDIES OF THE BILATERAL LOWER EXTREMITIES: 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), Low Back, Lumbar and Thoracic (Acute and Chronic)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM V.3 > LOW BACK > DIAGNOSTIC AND TREATMENT CONSIDERATIONS > ELECTROMYOGRAPHY

**Decision rationale:** The MTUS does not address the topic of nerve conduction testing of the lower extremities in conjunction with an individual with low back pain, such as the applicant. While the Third Edition ACOEM Guidelines do endorse electrodiagnostic testing, including EMG and/or NCV testing in an individual with persistent low back and/or leg complaints in whom radiculopathy and/or peripheral neuropathy is suspected, ACOEM further notes that NCV testing is "usually normal in radiculopathy." While nerve conduction testing can identify or

detect a suspected peripheral neuropathy, in this case, however, there is no indication or evidence that the applicant has a diagnosis or suspected diagnosis of peripheral neuropathy. There is no mention of diabetes, hypertension, or other systemic disease process which would make a peripheral neuropathy more likely. Accordingly, the request is likewise not certified, on Independent Medical Review.

**ELECTROMYOGRAPHY OF THE BILATERAL LOWER EXTREMITIES:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Lumbar and Thoracic (Acute and Chronic)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

**Decision rationale:** As noted in the MTUS-adopted ACOEM Guidelines in Chapter 12, Table 12-8, EMG testing is "recommended" to clarify a suspected diagnosis of nerve root dysfunction. In this case, the attending provider has seemingly posited that the applicant has lumbar radiculopathy which has eluded detection on MRI imaging. The applicant does have ongoing complaints of low back pain radiating to the legs with some hyposensorium weakness appreciated on exam. Electrodiagnostic testing to more clearly delineate the same is indicated and appropriate. Therefore, the original utilization review decision is overturned. The request is certified, on Independent Medical Review.

**PURCHASE OF TENS UNIT:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS, Chronic Pain (Transcutaneous Electrical Nerve Stimulation).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308.

**Decision rationale:** As noted in the MTUS-adopted ACOEM Guidelines in Chapter 12, Table 12-8, TENS units are "not recommended." While ACOEM Chapter 12, page 300 does suggest that TENS may have some value in the short-term if used in conjunction with a program of functional restoration, in this case, however, the applicant is not intent on functional restoration. The applicant is off of work, on total temporary disability. The applicant seemingly has no intention of returning to the workplace and/or workforce. It is not clearly stated that the TENS unit is in fact intended to be employed in conjunction with a program of functional restoration. There is, furthermore, no indication that the applicant had obtained and/or received a successful trial of the TENS unit before purchase of the device was sought. Accordingly, the request is likewise not certified, for all of the stated reasons.

**PURCHASE OF HOT/COLD UNIT:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 161, 162, 300.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308.

**Decision rationale:** As noted in the MTUS-adopted ACOEM Guidelines in Chapter 12, page 308, at-home applications of local heat and cold to the low back are "optional." ACOEM states that simple, low-tech, at-home applications of heat and cold are considered part and parcel of self-care and are as effective as applications of heat and cold performed by physical therapist or, by implication, through the high-tech means proposed by the attending provider. In this case, the attending provider has not proffered any applicant-specific rationale or commentary to the request for authorization so as to try and offset the unfavorable ACOEM recommendation. The attending provider has not clearly stated why the applicant cannot employ simple, low-tech applications of heat and cold. Therefore, the request is likewise not certified, on Independent Medical Review.