

<b>Case Number:</b>	CM13-0049815		
<b>Date Assigned:</b>	12/27/2013	<b>Date of Injury:</b>	06/29/2013
<b>Decision Date:</b>	02/20/2014	<b>UR Denial Date:</b>	10/11/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/08/2013

### 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 Occupational Medicine and is licensed to practice in Hawaii. 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 patient is a 41 year old male with a date of injury of 6/29/2013. Medical records indicate that the injured worker was being treated for low back with radiculopathy to right leg. Additionally, he complains of tenderness to right leg along with "sharp, aching, spasmodic and shooting." Objective findings on 10/3/2013 by [REDACTED] include positive straight leg raise test to 55 degree and 45 degrees to right and left leg, respectively. Otherwise normal neurological examination noted. Decreased range of motion to lumbar spine (flexion, extension, lateral bending) also observed. His medical records indicate that treatment has included lumbar x-ray, cyclobenzaprine 10mg nightly, hydrocodone-acetaminophen 5/500mg three times daily, tramadol, toradol injection, tyenol #3 nightly and physical therapy. A utilization review (10/11/2013) modified a request for 12 chiropractic sessions to 6, certified naproxen 550mg #60, noncertified a baseline functional capacity evaluation, tramadol #90, inferential unit, cyclo-keto-lido cream, and urine drug test.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Chiropractic manipulation (12 sessions): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 58-60.

**Decision rationale:** The MTUS clearly states that chiropractic manipulation for the low back is recommended as an option. Therapeutic care should be as a trial of 6 visits over 2 weeks, and with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Elective /maintenance care is not medically necessary. Treatment for recurrences/flare-ups requires a reevaluation for treatment success, if return to work achieved then 1-2 visits every 4-6 months. The treating provider has not demonstrated evidence of objective and measurable functional improvement during or after the trial of therapeutic care to warrant extension of this care, which is necessary under MTUS guidelines. As such, the request for 12 sessions of chiropractic manipulation is not medically necessary.

**baseline functional capacity evaluation:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines, Chapter 7, page 127, and the Official Disability Guidelines (ODG).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 2 General Approach to Initial Assessment and Documentation Page(s): 21-42. Decision based on Non-MTUS Citation ODG, Fitness for Duty Chapter, Functional Capacity Evaluation (FCE).

**Decision rationale:** ACOEM guidelines state to consider using a functional capacity evaluation when necessary to translate medical impairment into functional limitations and determine work capability. Additionally, the guidelines indicate that it may be necessary to obtain a more precise delineation of patient capabilities than is available from routine physical examination. Under some circumstances, this can best be done by ordering a functional capacity evaluation of the patient. Progress notes by the treating physicians clearly outline what the patient's limitations are and make no indication that additional delineation of the patient's capabilities are necessary to determine return to work. ODG further specifies that functional capacity evaluations are recommended prior to admission to a Work Hardening (WH) Program. An FCE is time-consuming and cannot be recommended as a routine evaluation. The guidelines recommend to consider an FCE if 1. Case management is hampered by complex issues such as: - Prior unsuccessful RTW attempts. - Conflicting medical reporting on precautions and/or fitness for modified job. - Injuries that require detailed exploration of a worker's abilities. 2. Timing is appropriate: - Close or at MMI/all key medical reports secured. - Additional/secondary conditions clarified." The medical documents provided do not indicate that any of the above criteria were met. As such, the request for baseline functional capacity evaluation is not medically indicated.

**interferential unit:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315, Chronic Pain Treatment Guidelines Interferential Current Stimulation, Transcutaneous Electrotherapy Page(s): 54, 114-116.

**Decision rationale:** ACOEM guidelines state that insufficient evidence exists to determine the effectiveness of sympathetic therapy, a noninvasive treatment involving electrical stimulation, also known as interferential therapy. At-home local applications of heat or cold are as effective as those performed by therapists. MTUS further states that this type of treatment is not recommended as an isolated intervention. The guidelines further detail possible criteria for selection including that: pain is ineffectively controlled due to diminished effectiveness of medications; or - pain is ineffectively controlled with medications due to side effects; or - History of substance abuse; or - Significant pain from postoperative conditions limits the ability to perform exercise programs/ physical therapy treatment; or - pain is unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). If those criteria are met, then a one-month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits. The treating physician's progress notes do not indicate that the patient has poorly controlled pain, concerns for substance abuse, pain from postoperative conditions that limit ability to participate in exercise programs/treatments, or is unresponsive to conservative measures. As such, current request for interferential unit is not medically necessary.

**Tramadol #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Tramadol Page(s): 74-96, 113, 123.

**Decision rationale:** The medical documents provided indicate that the patient was concurrently prescribed naproxen 550mg one tablet twice a day, which is appropriate. MTUS states regarding tramadol that therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Before initiating therapy, the patient should set goals, and the continued use of opioids should be contingent on meeting these goals. The treating physician did not provide sufficient documentation that the patient has failed his trial of non-opioid analgesics at the time of prescription or in subsequent medical notes. Additionally, no documentation was provided that discussed the setting of goals for the use of tramadol prior to the initiation of this medication. As such, the request for tramadol #90 is not medically necessary.

**Ultram:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Tramadol Page(s): 74-96, 113, 123.

**Decision rationale:** Ultram is the brand name version of tramadol. The request for tramadol was not medically necessary, as discussed above. As such, the request for Ultram is also not medically necessary.

**Compounded cyclobenzaprine/ketoprofen/lidocaine cream:** 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 Topical Analgesics, Page(s): 111-113. Decision based on Non-MTUS Citation ODG, Pain Chapter, Muscle Relaxants and Compound Creams.

**Decision rationale:** ODG recommends usage of topical analgesics as an option, but also further details that they are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Ketoprofen is not currently FDA approved for a topical application. It has an extremely high incidence of photocontact dermatitis and photosensitization reactions. ODG also states that topical lidocaine is appropriate in usage as patch under certain criteria, but that no other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain other than Lidoderm patches. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Lidocaine and ketoprofen are not recommended for this specific usage. As such, the request for Cyclobenzaprine/Ketoprofen/Lidocaine cream is not medically necessary.

**urine drug test:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation University of Michigan Health System Guidelines for Clinical Care, Managing Chronic Non-Terminal Pain.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-96.

**Decision rationale:** MTUS states that use of urine drug screening for illegal drugs should be considered before therapeutic trial of opioids are initiated. The patient had already been dispensed opioid containing medication prior to the request of urine drug testing. Documentation of misuse of medications (doctor-shopping, uncontrolled drug escalation, drug diversion) would indicate need for urine drug screening. There is insufficient documentation provided to suggest issues of abuse, addiction, or poor pain control by the treating physician. Additionally, an initial trial of opioids is not recommended, based on the medical documents provided. As such, the current request for quantitative drug screen is not medically necessary.