

<b>Case Number:</b>	CM13-0060042		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	03/30/2012
<b>Decision Date:</b>	05/29/2014	<b>UR Denial Date:</b>	11/01/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/02/2013

### 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 Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas. 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 patient is a 30-year-old male who reported injury on 03/30/2012 with a mechanism of injury that was not provided. The patient's medication history included NSAIDs and muscle relaxants as of 02/2013, opioids since 04/2013 and Prilosec and topical creams as of 05/2013. The recent note dated 10/16/2013 revealed the patient had persistent low back pain that was increased with slight bending or squatting and standing up. It was indicated the patient had increased pain and muscle spasm. The muscle relaxants were noted to be helpful. The patient's diagnoses were noted to include discogenic lumbar condition with facet inflammation. The treatment request was made for naproxen sodium, Terocin, tramadol ER, Protonix to buffer the stomach for the history of gastritis, LidoPro and Flexeril. The additional treatment was for an EMG/NCV of the bilateral lower extremities.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**TRAMADOL ER 150MG #30:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Ongoing Management Page(s): 78.

**Decision rationale:** California MTUS guidelines recommend opiates for chronic pain. There should be documentation of an objective improvement in function, objective decrease in the VAS score, and evidence that the patient is being monitored for aberrant drug behavior and side effects. The clinical documentation submitted for review indicated the patient was taking opioids since 04/2013. There was a lack of documentation of an objective improvement in function, objective decrease in the VAS score and evidence that the patient was being monitored for aberrant drug behavior and side effects. Given the above, the request for tramadol ER 150 mg #30 is not medically necessary.

**NAPROXEN SODIUM 550MG #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67.

**Decision rationale:** California MTUS Guidelines indicate that NSAIDs are recommended for short-term symptomatic relief of low back pain. There should be documentation of an objective functional improvement and of an objective decrease in the VAS score. The patient was noted to be taking NSAIDs as of 02/2013. There was a lack of documentation indicating the patient had documented objective functional improvement and objective decrease in the VAS score with the medication. Given the above, the request for naproxen sodium 550 mg #60 is not medically necessary.

**PROTONIX 20MG #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs & GI symptoms Page(s): 69.

**Decision rationale:** California MTUS Guidelines indicate that PPIs are appropriate for the treatment of dyspepsia secondary to NSAID therapy. The patient was taking the medication as of 05/2013 documentation. There was a lack of documentation of the efficacy of the requested medication. As the NSAID was not medically necessary, the request for Protonix 20 mg #60 is not medically necessary.

**TEROCIN PATCH #20:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 28, 105, 111 and 112. Decision based on Non-MTUS Citation drugs.com.

**Decision rationale:** California MTUS indicates 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 antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. Lidocaine is approved as brand, Lidoderm. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. Per Drugs.com, Terocin is a topical analgesic containing capsaicin / lidocaine / menthol / methyl salicylate. The clinical documentation submitted for review failed to indicate the patient had a trial and failure of antidepressants and anticonvulsants and had not responded or was intolerant to other treatments. There was a lack of documentation of exceptional factors to warrant non-adherence to guideline recommendations. Given the above, the request for Terocin patch #20 is not medically necessary.

**LIDOPRO LOTION 4OZ:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 28, 105, 111 and 112. Decision based on Non-MTUS Citation drugs.com.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** California MTUS indicates 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 antidepressants and anticonvulsants have failed. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. Lidocaine is approved as brand, Lidoderm. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. Per drugs.com, LidoPro is a topical analgesic containing capsaicin / lidocaine / menthol / methyl salicylate. The clinical documentation submitted for review failed to indicate the patient had a trial and failure of antidepressants and anticonvulsants and failed to indicate the necessity for 2 topical creams containing Lidocaine. The clinical documentation failed to include documentation of exceptional factors to warrant non-adherence to guideline recommendations. Given the above, the request for LidoPro lotion 4 oz. is not medically necessary.

**FLEXERIL 7.5MG #60:** Upheld

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

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

**Decision rationale:** California MTUS guidelines recommend muscle relaxants as a second line option for the short term treatment of acute low back pain and their use is recommended for less than 3 weeks. There should be documentation of objective functional improvement. The clinical documentation submitted for review does provide evidence that the patient has been on this medication for an extended duration of time and there is a lack of documentation of objective improvement. Therefore, continued use of this medication would not be supported. Flexeril 7.5 mg #60 is not medically necessary.

**EMG OF THE BILATERAL LOWER EXTREMITIES:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

**Decision rationale:** ACOEM states that Electromyography (EMG), including H reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. The clinical documentation submitted for review indicated the request was due to left-sided radicular pain, numbness and tingling. The physician documentation indicated the request was for bilateral studies. However, it failed to provide myotomal and dermatomal deficits to support the necessity for an EMG and failed to provide rationale for bilateral studies. The request as submitted failed to indicate the laterality for the examination. Given the above, the request for an EMG is not medically necessary.

**NCV FOR THE BILATERAL LOWER EXTREMITIES:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**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 Chapter, NCS.

**Decision rationale:** Official Disability Guidelines do not recommend NCS as there is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. The clinical documentation submitted for review indicated the request was made to evaluate for possible radiculopathy, for left-sided complaints, which would be assessed with an EMG. There was a lack of documentation indicating a necessity for bilateral studies and for an NCV as the patient had radicular complaints. Additionally, there was a lack of documentation indicating a rationale for both studies. Given the above, the request for Nerve Conduction Velocity Test (NCV) bilateral lower extremities is not medically necessary.