

<b>Case Number:</b>	CM14-0001678		
<b>Date Assigned:</b>	01/22/2014	<b>Date of Injury:</b>	05/14/1998
<b>Decision Date:</b>	06/27/2014	<b>UR Denial Date:</b>	12/31/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/06/2014

### 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 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:

Clinical Summary: The patient is a 47 year old male who was injured on 05/14/1998. The mechanism of injury is unknown. Prior treatment history has included AndroGel 5.0 1% topical cream, Colace 100 mg, Trazodone hydrochloride 50 mg, Celebrex 200 mg, Cymbalta 60 mg, Zanaflex 4 mg, Lyrica 100 mg, Provigil 200 mg, Fentanyl 75 mcg, MiraLax, Lipitor, and Monopril. The patient underwent L5-S1 laminectomy and L4-L5 discectomy of unknown dates; bilateral re-exploration L5-S1 with microsurgical lysis of epidural fibrosis and resection of recurrent herniated nucleus pulposus on 02/01/2012. There are no diagnostic studies for review. PR2 dated 07/16/2013 indicates the patient had complaints of chronic low back pain and bilateral leg pain. He reports his pain is consistent with his exercise program and he feels that this has been very helpful in managing his pain. He also reported more leg symptoms that is tingling and at times a burning sensation down both legs. He does have a reported history of low testosterone. Objective findings on exam revealed mild point tenderness to bilateral spinals and bilateral superior gluteal region. Motor strength exam was intact. He has decreased sensation in bilateral L5 and S1 dermatomes. Achilles reflex is hyperactive bilaterally. Patellar reflex is symmetric. Straight leg raise is negative. He has no evidence of hypertonicity or clonus. The patient is diagnosed with low back pain with lumbar radiculopathy, lumbar disc herniation and lumbosacral spondylosis. Prior UR dated 12/13/2013 states the request for Celebrex is non-certified as there is no documented functional improvement. The request for MRI of the lumbar spine with/without contrast is non-certified as there are no acute changes in neurologic deficits documented. The request for AndroGel is non-certified as there are no documented lab levels to support the claim of low testosterone levels or to show the effectiveness of this medication.&#8195;

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **CELEBREX 200MG:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: NSAIDs (NON-STEROIDAL ANTI-IMFAMMATORY DRUGS), CHRONIC PAIN MEDICAL TREATMENT GUIDELINES,

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68.

**Decision rationale:** According to the CA MTUS guidelines, Celebrex is a selective NSAID which is recommended for patients who are at an intermediate risk for GI events. The medical records document the patient was diagnosed with lumbosacral spondylosis, low back pain with lumbar radiculopathy and lumbar disc herniation. There is no documentation that the patient is at high risk of GI complications such as peptic ulcers, GI bleeding or perforation, concurrent use of ASA, corticosteroids, and/or anticoagulants. Further, there is no documentation of failure to respond to over-the-counter NSAIDs. Therefore, the request is not medically necessary according to the guidelines. The request is non-certified. &#8195;

### **ANDRO GEL PUMP 1.62 TOPICAL GEL:** 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 Other Medical Treatment Guideline or Medical Evidence: AndroGel Drugs.com <http://www.drugs.com/pro/androgel.html>

**Decision rationale:** The CA MTUS guidelines and ODG have not addressed the issue of dispute. According to referenced guidelines, Androgel is recommended for primary hypogonadism (congenital or acquired): testicular failure due to conditions such as cryptorchidism, bilateral torsion, orchitis, vanishing testis syndrome, orchiectomy, Klinefelter's syndrome, chemotherapy, or toxic damage from alcohol or heavy metals. These men usually have low serum testosterone concentrations and gonadotropins (follicle-stimulating hormone [FSH], luteinizing hormone [LH]) above the normal range. The medical records document the patient was diagnosed with lumbosacral spondylosis, low back pain with lumbar radiculopathy and lumbar disc herniation. In the absence of documented low level of LH, FSH and testosterone levels, the request is not medically necessary according to the guidelines. The request for ANDRO GEL PUMP 1.62 TOPICAL GEL is non-certified. &#8195;

### **MRI OF THE LUMBAR SPINE WITH/WITHOUT CONTRAST:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: , CHAPTER 12- LOW BACK COMPLAINTS, 287

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, MRI

**Decision rationale:** According CA MTUS guidelines, MRI may be useful in isolating diagnoses that do not lend themselves to back surgery, such as sciatica caused by piriformis syndrome in the hip. It is recommended in cases of disc protrusion, cauda equina syndrome, spinal stenosis and post laminectomy syndrome. According to ODG, MRI is the test of choice for patients with prior back surgery, and if there is severe or progressive neurologic deficits. The medical records document the patient was diagnosed with lumbosacral spondylosis, low back pain with lumbar radiculopathy and lumbar disc herniation. In the visit note dated 07/16/2013 revealed the patient had complained of persistent tingling and at times burning-like sensation down both legs. On examination, there was decreased sensation on the bilateral L5 and S1 with hypoactive Achilles tendon reflex. The patient continues with HEP with some improvement and but continues to have low back pain. There is documentation of subjective and objective findings that indicate the medical necessity of lumbar spine MRI and hence the request is medically necessary according to the guidelines and is certified. &#8195;