

<b>Case Number:</b>	CM14-0006956		
<b>Date Assigned:</b>	02/07/2014	<b>Date of Injury:</b>	07/28/2013
<b>Decision Date:</b>	07/23/2014	<b>UR Denial Date:</b>	12/18/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/18/2014

### 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 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 patient is a 27-year-old male who has submitted a claim for headaches, cervical spine sprain/strain, lumbar spine strain/sprain, left elbow internal derangement, and right knee internal derangement associated with an industrial injury date of 12/17/2013. Medical records from 2013 were reviewed. The patient complained of frequent right-sided neck pain, radiating up to the jaw line and down to mid-thoracic. It was described as dull, achy, associated with stiffness and tingling sensation, graded 6-8/10 in severity. The patient likewise reported low back pain described as sharp, burning, stabbing, associated with numbness and tingling sensation, graded 8-9.5/10 in severity. Occasional left elbow and right knee pain were also reported. Alleviating factors included rest, massage, and intake of medications. Aggravating factors included neck movements, lifting more than 5 pounds, pushing, pulling, reaching, prolonged standing and walking for 20 minutes. Physical examination of the cervical and lumbar spine showed restricted range of motion. Provocative tests were negative. Motor strength, reflexes and sensory exam were normal. MRI of the cervical spine, dated 10/30/2013, revealed early disc desiccation at C2-C3 to C6-C7 levels; focal central disc protrusion effacing the thecal sac at C5-C6; and unremarkable exiting nerve roots. MRI of the lumbar spine, dated 10/30/2013, revealed early disc desiccation at L5-S1; straightening of the lumbar spine; with patent spinal canal and neural foramina at all levels. The treatment to date has included ibuprofen, Vicodin, and topical compounds. Utilization review from 12/17/2013 denied the requests for interferential unit because there was no evidence of failure of conservative management; MRI of the cervical and lumbar spine due to lack of objective findings to support its use; Terocin 240 mL, topical compound flurbi cream and gabacyclotram because these are not recommended for topical use; Somnicin capsule because this is not guideline recommended; and Narcotic risk lab test because genetic testing for potential opioid abuse is not endorsed. The request for eight acupuncture

sessions was modified into six sessions to meet guideline recommendation for initial trial. The request for six chiropractic manipulations was likewise modified into six sessions as recommended by the guidelines.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **EIGHT ACUPUNCTURE SESSIONS: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** California MTUS Acupuncture Medical Treatment Guidelines state that acupuncture is used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Acupuncture treatments may be extended if functional improvement is documented. The frequency and duration to produce functional improvement is 3 - 6 treatments, frequency of 1 - 3 times per week, and duration of 1 - 2 months. In this case, patient complained of pain at the cervical and lumbar area. Acupuncture treatment may be a reasonable option, however, the present request of an initial trial of eight sessions exceeded the guideline recommendation. Moreover, body part to be treated was not specified. Therefore, the request for eight acupuncture sessions is not medically necessary.

#### **SIX CHIROPRACTIC MANIPULATIONS: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58-59.

**Decision rationale:** As stated on pages 58-59 of California MTUS Chronic Pain Medical Treatment Guidelines, several studies of manipulation have looked at duration of treatment, and they generally showed measured improvement within the first few weeks or 3-6 visits of chiropractic treatment, although improvement tapered off after the initial sessions. There should be some outward sign of subjective or objective improvement within the first 6 visits for continuing treatment. In this case, patient complained of pain at the cervical and lumbar area. Manipulation therapy may be a reasonable option. However, the specific body part to be treated was not specified. It is unclear whether lower levels of care were exhausted. It is unclear why chiropractic care would be requested concurrently with several other modalities, rendering any differential assessment of response void. Therefore, the request for six chiropractic manipulations is not medically necessary.

#### **ONE (1) INTERFERENTIAL UNIT: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118-120.

**Decision rationale:** As stated on pages 118-120 of the California MTUS Chronic Pain Medical Treatment Guidelines, interferential current stimulation is not recommended as an isolated intervention but is an adjunct for recommended treatments including return to work, exercise, and medications. A one-month trial should be done given that the patient's pain is ineffectively controlled by medications, or unresponsive to conservative measures. In this case, the documented indications are to reduce the need for medications and to increase joint range of motion while the patient is in a home exercise program. However, medical records submitted for review failed to provide evidence of failure in conservative management. It is unclear if the patient has attended the authorized physical therapy sessions to date. Moreover, the request failed to specify the duration of treatment, and if the device is for rental or purchase. Therefore, the request for one interferential unit is not medically necessary.

#### **MRI OF CERVICAL SPINE WITHOUT CONTRAST: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-180.

**Decision rationale:** California MTUS ACOEM guidelines support imaging studies with red flag conditions; physiologic evidence of tissue insult or neurologic dysfunction; failure to progress in a strengthening program intended to avoid surgery; clarification of the anatomy prior to an invasive procedure and definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans. In this case, the documented rationale for MRI is due to suspected disc protrusion. The patient complained of frequent right-sided neck pain, radiating up to the jaw line and down to mid-thoracic described as dull, achy, associated with stiffness and tingling sensation. However, physical examination merely showed restricted range of motion. Sensorimotor exam, provocative tests, and reflexes were unremarkable. There is no objective finding to support patient's symptoms. Moreover, a previous MRI of the cervical spine was accomplished on 10/30/2013 revealing early disc desiccation, focal central disc protrusion, with no nerve root impingement. There is no compelling rationale for repeat MRI at this time. Therefore, the request for MRI of the cervical spine without contrast is not medically necessary.

#### **MRI OF LUMBAR SPINE WITHOUT CONTRAST: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Section, MRI.

**Decision rationale:** As stated on pages 303-304 of the ACOEM Practice Guidelines referenced by California MTUS, imaging of the lumbar spine is recommended in patients with red flag diagnoses where plain film radiographs are negative; unequivocal objective findings that identify specific nerve compromise, failure to respond to treatment, and consideration for surgery. In addition, Official Disability Guidelines recommends MRI for the lumbar spine for uncomplicated low back pain with radiculopathy, after at least 1 month of conservative therapy, sooner if severe, or progressive neurologic deficit. In this case, the documented rationale for MRI is due to suspected disc protrusion. Patient complained of low back pain described as sharp, burning, stabbing, associated with numbness and tingling sensation. However, physical examination merely showed restricted range of motion. Sensorimotor exam, provocative tests, and reflexes were unremarkable. There is no objective finding to support patient's symptoms. Moreover, a previous MRI of the lumbar spine was accomplished on 10/30/2013 revealing early disc desiccation at L5-S1, patent spinal canal and neural foramina at all levels. There is no compelling rationale for repeat MRI at this time. Therefore, the request for MRI of the lumbar spine without contrast is not medically necessary.

**ONE PRESCRIPTION OF TEROGIN 240 ML:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Section, Topical Salicylates.

**Decision rationale:** As noted on pages 111-112 of the California MTUS Chronic Pain Medical Treatment guidelines, there is little to no research to support the use of Lidocaine for compounded products, and Lidocaine is not recommended for topical use. Terocin lotion contains: Methyl Salicylate 25%, Capsaicin 0.025%, Menthol 10%, and Lidocaine 2.50%. Regarding the Capsaicin component, the guideline states there is no current indication that an increase over a 0.025% formulation would provide any further efficacy. Regarding the Lidocaine component, California MTUS Chronic Pain Medical Treatment Guidelines identify on page 112 that topical formulations of Lidocaine (whether creams, lotions or gels) are not indicated for neuropathic or non-neuropathic pain complaints. According to the guideline, topical salicylate is significantly better than placebo in chronic pain. Regarding the Menthol component, California MTUS does not cite specific provisions, but the ODG Pain Chapter states that the FDA has issued an alert in 2012 indicating that topical OTC pain relievers that contain menthol, methyl salicylate, or capsaicin, may in rare instances cause serious burns. In this case, patient has been complaining of persistent low back and neck pain, radiating to the jaw line. However, guidelines state that any compounded product that contains at least one drug that is not recommended is not recommended. There is no discussion concerning intolerance to oral medications. Terocin

contains components that are not recommended for topical use. Therefore, the request for Terocin 240 mL is not medically necessary.

**ONE (1) PRESCRIPTION OF TOPICAL COMPOUND FLURBI CREAM #180 GM:**  
Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

**Decision rationale:** As noted on pages 111-113 in the California MTUS Chronic Pain Medical Treatment Guidelines, there is little to no research as for the use of Flurbiprofen in compounded products. There is little to no research as for the use of Flurbiprofen in compounded products. Topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. In this case, the patient has been complaining of persistent low back and neck pain, radiating to the jaw line. However, there is no discussion concerning intolerance to oral medications. There is likewise no documented rationale concerning the need for multiple topical compounded products. Therefore, the request for one (1) prescription of topical compound Flurbi cream #180 gm is not medically necessary.

**ONE (1) PRESCRIPTION OF COMPOUND GABACYCLOTRAM #180 GM:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-112.

**Decision rationale:** According to California MTUS Chronic Pain Medical Treatment Guidelines pages 111-113, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Gabapentin is not recommended for use as a topical analgesic. Likewise, Cyclobenzaprine has no evidence for use as a topical product. Tramadol is indicated for moderate to severe pain. In this case, patient has been complaining of persistent low back and neck pain, radiating to the jaw line. However, there is no discussion concerning intolerance to oral medications. There is likewise no documented rationale concerning the need for multiple topical compounded products. Therefore, the request for one (1) prescription of compound Gabacyclotram #180 gm is not medically necessary.

**ONE PRESCRIPTION SOMNICIN CAPSULES #30:** 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 Official Disability Guidelines (ODG) Pain Section, Medical Foods.

**Decision rationale:** The California MTUS does not specifically address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers Compensation, the Official Disability Guidelines (ODG), Pain Section was used instead. Somnicin #30 contains Melatonin, 5-hydroxytryptophan, L-tryptophan, Magnesium, and vitamin B-6. ODG states that medical foods are formulated for the specific dietary management of a disease or condition for which distinctive nutritional requirements, based on recognized scientific principles, are established by medical evaluation. 5-hydroxytryptophan has been found to be possibly effective in treatment of anxiety disorders, fibromyalgia, obesity, depression, and sleep disorders. In this case, the submitted records failed to include a rationale or laboratory values indicating nutritional deficiency. There is no discussion as to why this medication is being prescribed. A search in the FDA database did not provide any results for Somnicin. The FDA states that specific requirements for the safety or appropriate use of medical foods have not yet been established. Therefore, the request for one prescription Somnicin capsules #30 is not medically necessary.

**ONE (1) PROOVE BIOSCIENCES NARCOTICS RISK LAB TEST: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Drug Testing Page(s): 42.

**Decision rationale:** Page 42 of the California MTUS Chronic Pain Medical Treatment Guidelines state that cytokine DNA testing is not recommended. There is no current evidence to support its use for the diagnosis of pain, including chronic pain. In addition, ODG states that genetic testing for potential opioid abuse is not recommended. While there appears to be a strong genetic component to addictive behavior, current research is experimental in terms of testing for this. In this case, the documented indications are to identify the genetic risk factors of narcotic abuse, tolerance, and dependence; to improve the patient's outcome; and to avoid costs from unnecessary high-dose narcotic usage. However, there was no discussion concerning genetic predisposition towards addiction and opioid tolerance. Guidelines do not recommend genetic testing in general. The medical necessity has not been established. Therefore, the request for one (1) prove biosciences narcotics risk lab test is not medically necessary.