

<b>Case Number:</b>	CM14-0014190		
<b>Date Assigned:</b>	02/26/2014	<b>Date of Injury:</b>	06/16/2013
<b>Decision Date:</b>	09/09/2014	<b>UR Denial Date:</b>	01/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/04/2014

### 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:

This is a 46-year-old female patient with a 6/16/13 date of injury. 2/28/14 progress report indicates severe headaches, blurry vision, neck pain, back pain and persistent nausea. The patient has debilitating nausea, vomiting, headaches, dizziness, is unable to sleep, exudes personality changes, anxiety and depression. The patient has numbness and tingling down the arms as well as down the legs. Objective findings include exquisite tenderness along cervical and lumbar spine, guarded gait, pain on cervical flexion, and generalized weakness in the upper and lower extremities. There is no focal atrophy or weakness. Sensation is intact. 1/14/14 brain MRI demonstrates small scattered foci of increased signal within the white matter which may represent small vessel microvascular disease as well as focal areas of increased signal identified within the midbrain and pons consistent with areas of microinfarction as well as a 12 x 5 mm lacunar infarct in the inferior left cerebellum. 12/20/13 progress report indicates persistent neck pain, headaches, muscle spasm, stiffness, tightness, low back pain radiating down the bilateral lower extremities with numbness and tingling. Physical exam demonstrates cervical tenderness, decreased cervical range of motion, positive straight leg raise test. Gait is wide-based. Treatment to date has included Physical Therapy x6, chiropractor x12, medication, activity modification. There is documentation of a previous 1/8/14 adverse determination; with modification to 6 visits of PT/chiropractic care. Naproxen Sodium 550mg #60 was approved. Cervical MRI was denied for lack of focal neurologic deficits and lack of failure of conservative care; lumbar MRI was denied for lack of focal neurologic deficits and lack of failure of conservative care; EMG/NCV were denied for lack of focal neurologic deficits and lack of failure of conservative care; lack of neurologic complaints or blunt trauma to warrant neurology referral; back brace was denied because the injury was not acute and the patient is not postsurgical; there is no fracture, listhesis or instability; TENS was denied because there was not

TENS trial in PT and no evidence of failure of conservative management; cervical pillow was denied because there is no evidence of daily exercise; cervical collar was denied because the injury was not acute and there was no recent surgery; Terocin patches were denied because topical Lidocaine and topical Menthol are not supported by CA MTUS; Topamax was denied because two concurrent AEDs would not be supported by guidelines; Tramadol was denied for risk of Serotonin syndrome with Flexeril; LidoPro lotion was denied for lack of guidelines support; Protonix was non-certified for lack of increased upper GI risk.

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

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

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

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 177-178.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 179-180. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back Chapter, MRI.

**Decision rationale:** CA MTUS supports 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. However, there were no unequivocal objective findings that identify specific nerve compromise on the neurologic examination. Multiple pathologic lesions were identified on brain MRI, and a neurology consult is pending. Therefore, the request for MRI of the cervical spine was not medically necessary.

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

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 303-304.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304.

**Decision rationale:** CA MTUS supports imaging of the lumbar spine in patients with red flag diagnoses where plain film radiographs are negative; unequivocal objective findings that identify specific nerve compromise on the neurologic examination, failure to respond to treatment, and consideration for surgery. However, there were no unequivocal objective findings that identify specific nerve compromise on the neurologic examination. Multiple pathologic lesions were identified on brain MRI, and a neurology consult is pending. Therefore, the request for MRI of the lumbar spine was not medically necessary.

#### **EMG BILATERAL UPPER EXTREMITIES: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 177-178.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 238. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (Neck and Upper Back Chapter) EMG.

**Decision rationale:** CA MTUS criteria for EMG/NCV of the upper extremity include documentation of subjective/objective findings consistent with radiculopathy/nerve entrapment that has not responded to conservative treatment. However, there were no focal neurologic deficits on physical exam. A neurology consult is pending, given the certification of an associated request. Therefore, the request for an EMG bilateral upper extremities was not medically necessary.

**EMG BILATERAL LOWER EXTREMITIES:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 177-178.

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

**Decision rationale:** CA MTUS states that electromyography (EMG), including H-reflex tests, are indicated to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three to four weeks. In addition, ODG states stat EMGs may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMGs are not necessary if radiculopathy is already clinically obvious. However, there were no focal neurologic deficits on physical exam. A neurology consult is pending, given the certification of an associated request. Therefore, the request for an EMG bilateral lower extremities was not medically necessary.

**12 SESSIONS OF PHYSICAL THERAPY/CHIROPRACTIC THERAPY:** 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), Physical Therapy Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL THERAPY Page(s): 98-99. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Pain, Suffering, and the Restoration of Function Chapter 6 (page 114).

**Decision rationale:** CA MTUS stresses the importance of a time-limited treatment plan with clearly defined functional goals, frequent assessment and modification of the treatment plan based upon the patient's progress in meeting those goals, and monitoring from the treating physician regarding progress and continued benefit of treatment is paramount. Physical Medicine Guidelines - Allow for fading of treatment frequency. However, the medical reports do not clearly establish objective and measured functional gains, improvement with activities of daily

living, or discussions regarding return to work as a result of previous physical therapy. In addition, the proposed number of visits in addition to the number of visits already completed would exceed guideline recommendations. There is no clear description of education with respect to independent exercises, compliance, or failure of an independent program to address the residual deficits. It is unclear why the previous modified certification for 6 additional visits would not suffice. Therefore, the request for 12 sessions of physical therapy/chiropractic therapy was not medically necessary.

**NEUROLOGY REFERRAL:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM GUIDELINES, pg. 127.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 6- Independent Medical Examinations and Consultations, (pp 127, 156); Official Disability Guidelines (ODG) Pain Chapter, Consultations.

**Decision rationale:** CA MTUS states that consultations are recommended, and a health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present or when the plan or course of care may benefit from additional expertise. The patient presents with headaches, blurry vision, neck pain, back pain and persistent nausea. The patient has debilitating nausea, vomiting, headaches, dizziness, is unable to sleep, exudes personality changes, anxiety and depression. The patient has numbness and tingling down the arms as well as down the legs. Objective findings include exquisite tenderness along cervical and lumbar spine, guarded gait, pain on cervical flexion, and generalized weakness in the upper and lower extremities. There is no focal atrophy or weakness. Sensation is intact. 1/14/14 brain MRI demonstrates small scattered foci of increased signal within the white matter which may represent small vessel microvascular disease as well as focal areas of increased signal identified within the midbrain and pons consistent with areas of microinfarction as well as a 12 x 5 mm lacunar infarct in the inferior left cerebellum. Therefore, the request for a neurology referral was not medically necessary.

**LOW BACK BRACE:** 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).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

**Decision rationale:** CA MTUS states that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief; however, ODG states that lumbar supports are not recommended for prevention; as there is strong and consistent evidence that lumbar supports were not effective in preventing neck and back pain. They are recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented

instability, and for treatment of nonspecific LBP as a conservative option. However, the patient's injury is chronic in nature. There is no evidence of instability, compression fractures, or instability. Therefore, the request for a low back brace was not medically necessary.

**RETROSPECTIVE TENS UNIT, DOS: 12/20/13: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS UNIT Page(s): 114-116.

**Decision rationale:** CA MTUS Chronic Pain Medical Treatment Guidelines state that a one-month trial period of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function and that other ongoing pain treatment should also be documented during the trial period including medication. However, there is little information regarding this patient's treatment history over the last months including the use of a TENS unit in physical therapy, medication management, or instruction and compliance with an independent program. There is no specific duration or request for a trial. Therefore, the request for a retrospective TENS Unit, DOS: 12/20/13 was not medically necessary.

**RETROSPECTIVE CERVICAL PILLOW, DOS: 12/20/13: 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).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back Chapter, Cervical Pillow.

**Decision rationale:** CA MTUS does not address this request. ODG recommends use of a neck support pillow while sleeping, in conjunction with daily exercise; either strategy alone did not give clinical benefit. However, there is no evidence that the cervical pillow would be used in conjunction with a home exercise program. Therefore, the request for retrospective cervical pillow, DOS: 12/20/13 was not medically necessary.

**RETROSPECTIVE CERVICAL COLLAR WITH GEL, DOS: 12/20/13: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 175.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back Chapter, Collars.

**Decision rationale:** CA MTUS does not apply. ODG does not recommend cervical collars for neck sprains, but may be appropriate where post-operative and fracture indications exist. However, there remains no evidence of recent or pending surgery or cervical fracture. Therefore, the request for retrospective cervical collar with gel, DOS: 12/20/13 was not medically necessary.

**RETROSPECTIVE TEROGIN PATCHES #20, DOS: 12/20/13: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Terocin Patch Page(s): 112. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: <http://dailymed.nlm.nih.gov/dailymed/lookup.cfm?setid=100ceb76-8ebe-437b-a8de-37cc76ece9bb>.

**Decision rationale:** MTUS chronic pain medical treatment guidelines states that topical Lidocaine in the formulation of a dermal patch has been designated for orphan's status by the FDA for neuropathic pain. In addition, CA MTUS states that topical Lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as Gabapentin or Lyrica). However, there is no clear evidence of failure of a recent trial of first line therapy; Gabapentin was just certified on 1/8/14. Therefore, the request for retrospective Terocin Patches #20, DOS: 12/20/13 was not medically necessary.

**RETROSPECTIVE TOPOMAX 50MG #60, DOS: 12/20/13: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topamax Page(s): 16-21.

**Decision rationale:** CA MTUS Chronic Pain Medical Treatment Guidelines state that Topiramate is considered for use for neuropathic pain when other anticonvulsants fail. However, there is no evidence that other anticonvulsants have failed. Therefore, the request for retrospective Topamax 50mg #60, DOS: 12/20/13 was not medically necessary.

**RETROSPECTIVE NAPROXEN SODIUM 550MG #60, DOS: 12/20/13: 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 based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, NSAIDs.

**Decision rationale:** CA MTUS states that NSAIDs are effective, although they can cause gastrointestinal irritation or ulceration or, less commonly, renal or allergic problems. Studies have shown that when NSAIDs are used for more than a few weeks, they can retard or impair bone, muscle, and connective tissue healing and perhaps cause hypertension. In addition, ODG states that there is inconsistent evidence for the use of these medications to treat long-term neuropathic pain, but they may be useful to treat breakthrough pain. However, the previous request for retrospective Naproxen Sodium 550mg #60, DOS: 12/20/13 was deemed medically necessary with the previous UR decision. Therefore, a repeat certification for retrospective Naproxen Sodium 550mg #60, DOS: 12/20/13 is now not medically necessary.

**RETROSPECTIVE 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 OPIATES Page(s): 78-81.

**Decision rationale:** CA MTUS Chronic Pain Medical Treatment Guidelines do not support ongoing opioid treatment unless prescriptions are from a single practitioner and are taken as directed; are prescribed at the lowest possible dose; and unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. However, an opioid utilization timeline was not established. There is sparse information in the most recent medical report as to the domains of ongoing opioid management, including monitoring for diversion, abuse, side effects, or tolerance development; dosage adjustments, attempts to wean and taper, endpoints of treatment; and continued efficacy and compliance. There remains concern over the risk of Serotonin syndrome with concurrent Flexeril use. Therefore, the request for retrospective Tramadol ER 150mg #30 was not medically necessary.

**RETROSPECTIVE LIDOPRO LOTION, 4 OUNCES, DOS: 12/20/13: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Compound Creams Page(s): 111-113.

**Decision rationale:** CA MTUS Chronic Pain Medical Treatment Guidelines state that there is little to no research to support the use of NSAIDs, opioids, capsaicin, local anesthetics, antidepressants, glutamate receptor antagonists, -adrenergic receptor agonist, adenosine, cannabinoids, cholinergic receptor agonists, agonists, prostanoids, bradykinin, adenosine triphosphate, biogenic amines, and nerve growth factor in topical compound formulations. In addition, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. There remains sparse documentation as to why the prescribed compound formulation would be required despite adverse evidence. Therefore, the

request for retrospective Lidopro Lotion, 4 ounces, and DOS: 12/20/13 was not medically necessary.