

<b>Case Number:</b>	CM14-0014517		
<b>Date Assigned:</b>	02/28/2014	<b>Date of Injury:</b>	10/13/2013
<b>Decision Date:</b>	07/16/2014	<b>UR Denial Date:</b>	01/20/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/05/2014

### 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 Family Medicine, and is licensed to practice in Arizona. 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:

Patient is a 51-year-old female with a date of injury on October 13, 2013. Diagnoses include lumbar disc displacement, and lumbar sprain. Subjective complaints are of low back pain rated 6/10 with radiation to the right leg. Physical exam shows tenderness over the lumbar paravertebral area, decreased lumbar range of motion, no lower extremity weakness, and 2/4 bilateral reflexes. Straight leg raising test is negative. Prior treatments include chiropractic, and at least six visits of physical therapy. Medications include Lisinopril, gabapentin, tagamet, Norco 10mg four times per day, and tramadol. MRI from December 9, 2013 showed L3-L5 bulging discs.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PHYSICAL THERAPY TWO (2) TIMES A WEEK FOR THREE (3) WEEKS FOR THE LUMBAR SPINE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 114. Decision based on Non-MTUS Citation ODG, Low Back Chapter.

**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, PHYSICAL THERAPY.

**Decision rationale:** The ODG recommends allowance for fading of treatment frequency (from up to three or more visits per week to one or less), plus active self-directed home physical therapy. For lumbar sprains/strains and for intervertebral disc disorders the recommended physical therapy is ten sessions over eight weeks. For this patient, 6 sessions of physical therapy have been completed. The request for physical therapy for the lumbar spine, twice weekly for three weeks, is not medically necessary or appropriate.

**ELECTROMYOGRAM (EMG) OF THE BILATERAL LOWER EXTREMITIES:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 303. Decision based on Non-MTUS Citation ODG, Low Back Chapter.

**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, EMG.

**Decision rationale:** The Low Back Complaints Chapter of the ACOEM Practice Guidelines suggests that EMG/NCS (nerve conduction studies) may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than three or four weeks. The ODG recommends that EMG may be useful to obtain unequivocal evidence of radiculopathy after one month of conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. For this patient, lumbar radicular signs are present, and symptoms are corroborated by MRI findings. Therefore, the request for EMG of the bilateral lower extremities is not medically necessary or appropriate.

**NERVE CONDUCTION STUDIES (NCS) OF THE BILATERAL LOWER EXTREMITIES:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 303. Decision based on Non-MTUS Citation ODG, Low Back Chapter.

**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, NCS.

**Decision rationale:** The ODG does not recommend NCS due to minimal justification for performing NCS when a patient is presumed to have symptoms of radiculopathy, rather EMG is recommended as an option. This patient has low back pain with objective signs of radiculopathy, and is corroborated by MRI findings. The request for an NCS of the bilateral lower extremities is not medically necessary or appropriate.

**NORCO 5/325MG (ORAL), #60 WITH ONE (1) REFILL:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-going Management Page(s): 79-81. Decision based on Non-MTUS Citation ODG, Pain Chapter.

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

**Decision rationale:** The patient in question has been on chronic opioid therapy. CA Chronic Pain Guidelines has specific recommendations for the ongoing management of opioid therapy. Clear evidence should be presented about the degree of analgesia, level of activity of daily living, adverse side effects, or aberrant drug taking behavior. Guidelines for chronic back pain indicate that while opioid therapy can be efficacious it is limited to short term pain relief and long term efficacy (>16 weeks) is unclear, and failure to respond to limited course of medication suggests reassessment and consideration for alternative therapy. For this patient, no documentation is present of MTUS opioid compliance guidelines, including risk assessment, attempt at weaning, updated urine drug screen, and ongoing efficacy of medication. For this patient, there is no demonstrated improvement in pain or function from long-term use. For these reasons, the requested Norco is not medically necessary.

**COMPOUNDED CYCLO, KETO AND LIDO, 240GMS WITH ONE (1) REFILL:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS, LIDODERM Page(s): 111-113, 56.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines are clear that if the medication contains one drug that is not recommended the entire product should not be recommended. This product combines cyclobenzaprine, ketoprofen, and lidocaine. Guidelines do not recommend topical cyclobenzaprine as no peer-reviewed literature supports its use. The Chronic Pain Medical Treatment Guidelines indicates that topical NSAIDs (non-steroidal anti-inflammatory drugs) have been shown in meta-analysis to be superior to placebo during the first two weeks of treatment for osteoarthritis, but with a diminishing effect over another two week period. The NSAID in this compound is ketoprofen, which is not currently FDA approved for a topical application. Lidocaine is only recommended as a dermal patch. No other commercially approved topical formulations of lidocaine are indicated. The request for compounded cyclo, keto and lido, 240gms with one refill is not medically necessary or appropriate.

**FLEXERIL 7.5MG, #60 WITH ONE (1) REFILL:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63. Decision based on Non-MTUS Citation ODG, Pain Chapter.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CYCLOBENZAPINE Page(s): 41-42.

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines indicate that the use of cyclobenzaprine should be used as a short term therapy, and the effects of treatment are modest

and may cause adverse affects. This patient had been using muscle relaxers chronically, which is longer than the recommended course of therapy of two to three weeks. There is no evidence in the documentation that suggests the patient experienced improvement with the ongoing use of cyclobenzaprine. Due to clear guidelines suggesting cyclobenzaprine as short term therapy and no clear benefit from adding this medication the requested prescription for cyclobenzaprine is not medically necessary. Therefore, the request for flexeril 7.5mg, sixty count, with one refill, is not medically necessary or appropriate.