

<b>Case Number:</b>	CM14-0015216		
<b>Date Assigned:</b>	06/11/2014	<b>Date of Injury:</b>	09/19/2013
<b>Decision Date:</b>	10/02/2014	<b>UR Denial Date:</b>	01/13/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/06/2014

### 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 and is licensed to practice in Illinois. 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 injured worker is a 39-year-old male who reported an injury on 09/19/2013. The mechanism of injury involved repetitive activity. Current diagnoses include lumbar radiculopathy, insomnia, unspecified adjustment disorder, idiopathic peripheral autonomic neuropathy, and unspecified disorder of the autonomic nervous system. The injured worker was evaluated on 11/26/2013 with complaints of persistent lower back pain radiating into the bilateral lower extremities. It is noted that the injured worker has completed a short course of physical therapy. The physical examination on that date revealed tenderness to palpation of the lumbar paravertebral muscles with spasm, limited range of motion of the lumbar spine, positive straight leg raising on the left, 5/5 motor strength, and diminished sensation in the L5 and S1 nerve root distribution in the left lower extremity. Treatment recommendations at that time included prescriptions for omeprazole 20 mg, naproxen sodium 550 mg, Theramine, Sentra AM, Sentra PM, Gabadone, a course of acupuncture, chiropractic manipulation, physical therapy twice per week for 4 weeks, interferential unit, cardio-respiratory testing, a psychological evaluation, electrodiagnostic studies of the lower extremities, an MRI of the lumbar spine, and a narcotic risk laboratory test.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**PRESCRIPTION OF NAPROXEN SODIUM 550MG:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI SYMPTOMS & CARDIOVASULAR RISK,.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 67-72.

**Decision rationale:** California MTUS Guidelines state NSAIDs are recommended for osteoarthritis at the lowest dose for the shortest period in patients with moderate to severe pain. For acute exacerbations of chronic pain, NSAIDs are recommended as a second line option after acetaminophen. There is no frequency or quantity listed in the current request. As such, the request is non-certified.

**8 ACUPUNCTURE SESSIONS TWO TIMES PER WEEK FOR FOUR WEEKS, IN TREATMENT OF THE LUMBAR SPINE: Upheld**

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

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

**Decision rationale:** California MTUS Guidelines state acupuncture is used as an option when pain medication is reduced or not tolerated and may be used as an adjunct to physical rehabilitation and/or surgical intervention. The time to produce functional improvement includes 3 to 6 treatments. Therefore, the current request for 8 acupuncture sessions exceeds Guideline recommendations. As such, the request is non-certified.

**PRESCRIPTION OF OMEPRAZOLE 20MG, #90: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://www.drugs.com/pro/omeprazole.html>.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68-69.

**Decision rationale:** California MTUS Guidelines state proton-pump inhibitors are recommended for patients at intermediate or high risk for gastrointestinal events. Patients with no risk factor and no cardiovascular disease do not require the use of a proton-pump inhibitor, even in addition to a nonselective NSAID. There is no documentation of cardiovascular disease or increased risk factors for gastrointestinal events. There is also no frequency listed in the current request. As such, the request is non-certified.

**PRESCRIPTION OF CYCLOBENZAPRINE 7.5MG, #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines MUSCLE RELAXANTS (FOR PAIN),.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63-66.

**Decision rationale:** California MTUS Guidelines state muscle relaxants are recommended as non-sedating second line options for short term treatment of acute exacerbations. Flexeril should not be used for longer than 2 to 3 weeks. As per the documentation submitted, the injured worker's physical examination does reveal palpable muscle spasm. However, the California MTUS Guidelines do not recommend long term use of Cyclobenzaprine. There is no frequency listed in the current request. As such, the request is non-certified.

**PRESCRIPTION OF THERAMINE #90: 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) Chronic Pain Chapter, Theramine.

**Decision rationale:** California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no documentation of a failure to respond to first line oral medication prior to the initiation of a topical analgesic. There is also no frequency listed in the current request. As such, the request is non-certified.

**PRESCRIPTION OF SENTRA AM #60: 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) Chronic Pain Chapter, Medical Food.

**Decision rationale:** Official Disability Guidelines state medical food is a food which is formulated to be consumed or administered internally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements are established by medical evaluation. The medical necessity for the requested medication has not been established. There is also no frequency listed in the current request. As such, the request is non-certified.

**PRESCRIPTION OF SENTRA PM #60: 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) Chronic Pain Chapter, Sentra PM, Insomnia Treatment.

**Decision rationale:** Official Disability Guidelines recommend insomnia treatment based on etiology. Sentra PM is a medical food intended for the use in the management of sleep disorders associated with depression. The injured worker does not maintain a diagnosis of depression. There is also no indication of a failure to respond to first line treatment prior to the initiation of a prescription product.

**PRESCRIPTION OF GABADONE #60:** 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) Chronic Pain Chapter, Medical Food.

**Decision rationale:** Official Disability Guidelines state medical food is a food which is formulated to be consumed or administered internally under the supervision of a physician and which is intended for the specific dietary management of a disease or condition for which distinctive nutritional requirements are established by medical evaluation. The medical necessity for the requested medication has not been established. There is also no frequency listed in the current request. As such, the request is non-certified.

**6 VISITS OF CHIROPRACTIC MANIPULATION AND ANCILLARY PROCEDURES (NOT SPECIFIED), TWO TIMES PER WEEK FOR THREE WEEKS, TO THE LUMBAR SPINE:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines, Page 58. Page(s): 58.

**Decision rationale:** California MTUS Guidelines state manual therapy and manipulation is recommended if caused by a musculoskeletal condition. Treatment for the low back is recommended as an option with a therapeutic trial of 6 visits over 2 weeks. As per the documentation submitted, the injured worker's physical examination does reveal limited range of motion with tenderness to palpation and spasm. However, the current request for 6 visits of chiropractic manipulation and other ancillary procedures cannot be determined as medically appropriate. The additional ancillary procedures requested were not listed and would require separate review. As such, the request is non-certified.

**LUMBAR SPINE INTERFERENTIAL UNIT:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117-121.

**Decision rationale:** California MTUS Guidelines state interferential current stimulation is not recommended as an isolated intervention. There should be documentation that pain is ineffectively controlled due to diminished effectiveness of medications or side effects, a history of substance abuse, or significant pain from postoperative conditions. As per the documentation submitted, the injured worker has only participated in 6 sessions of physical therapy. There is no documentation of an exhaustion of conservative treatment. Furthermore, California MTUS Guidelines state if the device is to be used, a 1 month trial should be initiated. There is no total duration of treatment listed in the current request. Therefore, the request is non-certified.

**NERVE CONDUCTION VELOCITY (NCV) STUDY OF THE 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 based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Electrodiagnostic Testing.

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state electromyography may be useful to identify subtle, focal neurological dysfunction in patients with low back symptoms lasting more than 3 or 4 weeks. Official Disability Guidelines state electromyography may be useful to obtain unequivocal evidence of radiculopathy after 1 month of conservative therapy. Nerve conduction studies are not recommended. As per the documentation submitted, the injured worker's physical examination does reveal positive straight leg raising on the left with diminished sensation in the L5 and S1 nerve root distributions. However, there is no documentation of a significant musculoskeletal or neurological deficit with regard to the right lower extremity that would warrant the need for electrodiagnostic testing of the bilateral lower extremities. As such, the request is non-certified.

**ELECTROMYOGRAM (EMG) OF THE 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 based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Electrodiagnostic Testing.

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state electromyography may be useful to identify subtle, focal neurological dysfunction in patients with low back symptoms lasting more than 3 or 4 weeks. Official Disability Guidelines state electromyography may be useful to obtain unequivocal evidence of radiculopathy after 1 month of conservative therapy. Nerve conduction studies are not recommended. As per the documentation submitted, the injured worker's physical examination does reveal positive straight leg raising on the left with diminished sensation in the L5 and S1 nerve root distributions. However, there is no documentation of a significant musculoskeletal or neurological deficit with regard to the right lower extremity that would warrant the need for electrodiagnostic testing of the bilateral lower extremities. As such, the request is non-certified.

**MRI OF THE LUMBAR SPINE:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 303-305.

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state if physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultation the selection of an imaging test. Official Disability Guidelines state indications for imaging include thoracic or lumbar spine trauma with neurological deficit, uncomplicated low back pain with a suspicion for red flags, uncomplicated low back pain with radiculopathy after 1 month of conservative therapy, or myelopathy. As per the documentation submitted, the injured worker has previously undergone an MRI of the lumbar spine on 11/08/2013. There is no documentation of an exhaustion of conservative treatment or a progression or worsening of symptoms or physical examination findings that would warrant the need for a repeat MRI. As the medical necessity has not been established, the request is non-certified.

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

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

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

**Decision rationale:** California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is no documentation of a failure to respond to first line oral medication prior to the initiation of a topical analgesic. There is also no frequency listed in the current request. As such, the request is non-certified.

**PRESCRIPTION OF FLURB (NAP) CREAM 180GM:** Upheld

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

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

**Decision rationale:** California MTUS Guidelines state topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. The only FDA-approved topical NSAID is Diclofenac. Therefore, the request is not medically appropriate. There is also no frequency listed in the current request. As such, the request is non-certified.