

<b>Case Number:</b>	CM14-0112191		
<b>Date Assigned:</b>	08/01/2014	<b>Date of Injury:</b>	01/01/2008
<b>Decision Date:</b>	09/09/2014	<b>UR Denial Date:</b>	06/24/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/18/2014

### 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 Physical Medicine & Rehabilitation, and is licensed to practice in Nevada. 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 records, presented for review indicate that this 53-year-old gentleman was reportedly injured on January 1, 2008. The mechanism of injury was not listed in these records reviewed. The most recent progress note, dated June 6, 2014 indicated that there were ongoing complaints of low back pain. Pain was stated to be 10/10 without medications and 3/10 with medication. The physical examination demonstrated a wide-based gait and difficulty with heel/toe walking secondary to low back pain. There was tenderness over the lumbar paraspinal muscles and no facet tenderness. There was near full lumbar spine range of motion and a normal lower extremity neurological examination; treatment with rhizotomy was discussed. Diagnostic imaging studies were not reviewed during this visit. Previous treatment included a T12-L1 discectomy and a bilateral L4-L5 and L5-S1 medial branch block. A request had been made for cardio respiratory testing, probiotics, Flurbiprofen/Tramadol cream, and Gabapentin/ Amitriptyline/ Dextromethorphan cream and was not certified in the pre-authorization process on June 24, 2014.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Cardiorespiratory testing- autonomic function assessment: cardiovagal innervation, vasomotor adrenergic innervation, EKG: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Fitness for Duty; Autonomic Function Assessment; Role of Clinical Autonomic Testing in the Evaluation of Polyneuropathy and the National Guideline Clearinghouse (NGC).

**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, Preoperative Electrocardiogram, Updated August 22, 2014.

**Decision rationale:** According to the Official Disability Guideline, cardiac studies including an EKG are recommended only for individuals undergoing high risk surgery or for those undergoing intermediate risk surgeries that have additional risk factors. There is no justification in the attached medical record that the injured employee is in need of cardiorespiratory testing and surgeries are not planned at this time. Considering this, this request for cardiorespiratory testing- autonomic function assessment: Cardiovagal innervation, vasomotor adrenergic innervation, EKG is not medically necessary.

**1 prescription for probiotics #60: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Guideline Clearinghouse (NGC).

**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: <http://nccam.nih.gov/health/probiotics/introduction.htm>.

**Decision rationale:** Probiotics are dietary supplement often prescribed for various gastrointestinal conditions. It has no indication for treating low back pain or chronic pain syndromes. Considering this, the request for Probiotics is not medically necessary.

**Flurbiprofen 20%, tramadol 20% cream, 210gm: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26. MTUS (Effective July 18, 2009); Page(s): 111-113.

**Decision rationale:** According to the California Chronic Pain Medical Treatment Guidelines, the only recommended topical analgesic agents are those including anti-inflammatories, Lidocaine, or Capsaicin. There is no peer-reviewed evidence-based medicine to indicate that any other compounded ingredients have any efficacy. For this reason, this request for Flurbiprofen/Tramadol Cream is not medically necessary.

**Gabapentin 10%, amitriptyline 10%, dextromethorphan 10% cream, 210gm: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26. MTUS (Effective July 18, 2009) Page(s): 111-113.

**Decision rationale:** According to the California Chronic Pain Medical Treatment Guidelines, the only recommended topical analgesic agents are those including anti-inflammatories, Lidocaine, or Capsaicin. There is no peer-reviewed evidence-based medicine to indicate that any other compounded ingredients have any efficacy. For this reason, this request for Gabapentin/Amitriptyline/Dextromethorphan is not medically necessary.