

<b>Case Number:</b>	CM14-0136089		
<b>Date Assigned:</b>	09/29/2014	<b>Date of Injury:</b>	01/27/2000
<b>Decision Date:</b>	11/04/2014	<b>UR Denial Date:</b>	07/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/23/2014

### 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 and Rehabilitation and Pain 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 injured worker is a 55-year-old male who reported an injury on 01/27/2000 due to an unknown mechanism. Diagnoses were discogenic lumbar condition and status post fusion at L5-S1, with MRI showing bulging at L4-5 and L3-4. Nerve studies in 2007 were unremarkable. The injured worker had weight loss of 10 pounds and borderline hypertension. Physical examination on 08/20/2014 revealed complaints of chronic low back pain. There were also complaints of neck pain, muscle spasms, stiffness, and tightness. The injured worker was currently working. Examination revealed tenderness across the lumbar paraspinal muscles bilaterally. The injured worker had difficulty standing from a seated position. The injured worker could stand on toes and heels. Treatment plan was for imaging studies and to take medications as directed. Medications were Norco, Flexeril, Neurontin, Naproxen and Protonix. The rationale and Request for Authorization were not submitted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**One (1) Prescription Neurontin 600mg #90 between 7/15/2014 and 7/15/2014: Upheld**

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

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

**Decision rationale:** The request for One (1) Prescription Neurontin 600mg #90 between 7/15/2014 and 7/15/2014 is not medically necessary. The California Medical Guidelines indicate that gabapentin is shown to be effective for treatment of diabetes neuropathy and postherpetic neuralgia and has been considered as a first line treatment for neuropathic pain. The efficacy of this medication was not reported. The request does not indicate a frequency for the medication. There was no objective functional improvement reported for the injured worker. The clinical information submitted for review does not provide evidence to justify continued use. Therefore, this request is not medically necessary.

**One (1) Lab Studies to Include CMP, CBC and UA to Monitor Liver and Kidney Function between 7/15/2014 and 9/20/2014: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, Ongoing Management Page(s): 70, 78.

**Decision rationale:** The request for One (1) Lab Studies to Include CMP, CBC and UA to Monitor Liver and Kidney Function between 7/15/2014 and 9/20/2014 is not medically necessary. The California Medical Treatment Utilization Schedule recommend periodic lab monitoring of a chemistry profile (including liver and renal function). The guidelines recommend measuring liver transaminases within 4 to 8 weeks after starting therapy, but the interval of repeating lab tests after this treatment duration has not been established. Routine blood pressure monitoring is, however, recommended. The clinical documentation submitted for review does provide evidence that the injured worker has been on this medication for an extended duration of time. Based on the lack of documentation detailing a clear indication for the above lab studies, this request is not medically necessary. The medical guidelines also indicate that the use of urine drug screening is for patients with documented issues of abuse, addiction, or poor pain control. It was not reported that the injured worker had aberrant drug taking behaviors. Therefore, this request is not medically necessary.

**One (1) prescription Neurontin 600mg #90 between 7/15/2014 and 9/20/2014: Upheld**

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

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

**Decision rationale:** The request for One (1) Prescription Neurontin 600mg #90 between 7/15/2014 and 9/20/2014 is not medically necessary. The California Medical Guidelines indicate that gabapentin is shown to be effective for treatment of diabetes neuropathy and postherpetic neuralgia and has been considered as a first line treatment for neuropathic pain. The efficacy of this medication was not reported. The request does not indicate a frequency for the medication.

There was no objective functional improvement reported for the injured worker. The clinical information submitted for review does not provide evidence to justify continued use. Therefore, this request is not medically necessary.

**One (1) Prescription Norflex 100mg #60 between 7/15/2014 and 9/20/2014: Upheld**

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

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

**Decision rationale:** The request for One (1) Prescription Norflex 100mg #60 between 7/15/2014 and 9/20/2014 is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines recommend muscle relaxants as a second line option for the short term treatment of acute low back pain. Their use is recommended for less than 3 weeks. There should be documentation of objective functional improvement. The clinical documentation submitted for review does provide evidence that the patient has been on this medication for an extended duration of time. There is a lack of documentation of objective improvement. Therefore, continued use of this medication would not be supported. Therefore, this request is not medically necessary.

**One (1) Prescription Naproxen 550mg #60 between 7/15/2014 and 9/20/2014: Upheld**

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

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

**Decision rationale:** The decision for One (1) Prescription Naproxen 550mg #60 between 7/15/2014 and 9/20/2014 is not medically necessary. The California Medical Treatment Utilization Schedule indicates that NSAIDs are recommended for short term symptomatic relief of low back pain. It is generally recommended that the lowest effective dose be used for all NSAIDs for the shortest duration of time consistent with the individual patient treatment goals. There should be documentation of objective functional improvement and an objective decrease in pain. The efficacy of this medication was not reported. There was no documentation of objective decrease in pain or increase of activities of daily living. The request does not indicate a frequency for the medication. Therefore, this request is not medically necessary.

**One (1) Prescription LidoPro Cream #1 between 7/15/2014 and 9/20/2014: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Salicylate Topicals, page 105, Topical Analgesic, page 111, Topical Capsaicin, page 28, Lidocain.

**Decision rationale:** The decision for One (1) Prescription LidoPro Cream #1 between 7/15/2014 and 9/20/2014 is not medically necessary. The California MTUS guidelines indicate that topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. Capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. There have been no studies of a 0.0375% formulation of capsaicin and there is no current indication that this increase over a 0.025% formulation would provide any further efficacy. The guidelines indicate that topical lidocaine (Lidoderm) may be recommended for localized peripheral pain after there has been evidence of a trial of first line therapy (tricyclic or SNRI antidepressants or an AED such as gabapentin or Lyrica). No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. The guidelines recommend treatment with topical salicylates. Per drugs.com, LidoPro is a topical analgesic containing capsaicin/lidocaine/menthol/methyl salicylate. The medical guidelines do not support the use of compounded topical ointments. There were no other significant factors provided to justify the use outside of current guidelines. Therefore, this request is not medically necessary.

**One (1) Prescription of Terocin Patches #30 between 7/15/2014 and 9/20/2014:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Salicylate Topicals, page 105, Topical Analgesics, page 111, Topical Capsaicin, page 28, Lidocai.

**Decision rationale:** The decision for One (1) Prescription of Terocin Patches #30 between The request for Nine (9) Chiropractic Manipulation Treatments With Massage between 7/15/2014 and 9/20/2014 is not medically necessary. The California Medical Treatment Utilization Schedule states that manual therapy and manipulation is recommended for chronic pain if caused by musculoskeletal conditions. For the low back, therapy is recommended initially in a therapeutic trial of 6 sessions. With objective functional improvement, a total of up to 18 visits over 6 to 8 weeks may be appropriate. Treatment for flare ups requires a need for re-evaluation of prior treatment success. Treatment is not recommended for the ankle and foot, carpal tunnel syndrome, the forearm, wrist, hand, or knee. If chiropractic treatment is going to be effective, there should be some outward sign of subjective or objective improvement within the first 6 visits. Treatment beyond 4 to 6 visits should be documented with objective improvement in function. The maximum duration is 8 weeks. At 8 weeks, patients should be re-evaluated. Care beyond 8 weeks may be indicated for certain chronic pain patients in whom manipulation is helpful in improving function, decreasing pain and improving quality of life. Previous chiropractic manipulation treatments were not provided with an objective functional improvement. The request does not indicate what part of the body the treatment will be applied.

Therefore, this request is not medically necessary.is not medically necessary. The California MTUS guidelines indicate that topical analgesics are largely experimental in use with few randomized control trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Any compounded product that contains at least 1 drug (or drug class) that is not recommended is not recommended. Capsaicin is recommended only as an option in patients who have not responded or are intolerant to other treatments. The guidelines indicate that topical lidocaine (Lidoderm) may be recommended for localized peripheral pain after there has been evidence of a trial of first line therapy (tricyclic or SNRI antidepressants or an AED such as gabapentin or Lyrica). No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. The guidelines recommend treatment with topical salicylates. Per Drugs.com, Terocin is a topical analgesic containing capsaicin/lidocaine/menthol/methyl salicylate. The guidelines do not support the use of compounded topical analgesics. There were no other significant factors provided to justify the use outside of current guidelines. Therefore, this request is not medically necessary.

**One (1) Nerve Study of the Bilateral Lower Extremities between 7/15/2014 and 9/20/2014:**  
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) Nerve Conduction Studies (NCS)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

**Decision rationale:** The request for One (1) Nerve Study of the Bilateral Lower Extremities between 7/15/2014 and 9/20/2014 is not medically necessary. The California ACOEM states unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. Electromyography (EMG), including H reflex tests, may be useful to identify subtle, focal neurologic dysfunction in patients with low back symptoms lasting more than 3 or 4 weeks. Discography is not recommended for assessing patients with acute low back symptoms. There was no neurological exam reported on the physical examination. Therefore, no other significant factors provided to justify the use outside of current guidelines. Therefore, this request is not medically necessary.

**Nine (9) Chiropractic Manipulation Treatments With Massage between 7/15/2014 and 9/20/2014:** 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 Page(s): 58-59.

**Decision rationale:** The request for Nine (9) Chiropractic Manipulation Treatments With Massage between 7/15/2014 and 9/20/2014 is not medically necessary. The California Medical Treatment Utilization Schedule states that manual therapy and manipulation is recommended for chronic pain if caused by musculoskeletal conditions. For the low back, therapy is recommended initially in a therapeutic trial of 6 sessions. With objective functional improvement, a total of up to 18 visits over 6 to 8 weeks may be appropriate. Treatment for flare ups requires a need for re-evaluation of prior treatment success. Treatment is not recommended for the ankle and foot, carpal tunnel syndrome, the forearm, wrist, hand, or knee. If chiropractic treatment is going to be effective, there should be some outward sign of subjective or objective improvement within the first 6 visits. Treatment beyond 4 to 6 visits should be documented with objective improvement in function. The maximum duration is 8 weeks. At 8 weeks, patients should be re-evaluated. Care beyond 8 weeks may be indicated for certain chronic pain patients in whom manipulation is helpful in improving function, decreasing pain and improving quality of life. Previous chiropractic manipulation treatments were not provided with an objective functional improvement. The request does not indicate what part of the body the treatment will be applied. Therefore, this request is not medically necessary.