

<b>Case Number:</b>	CM14-0155203		
<b>Date Assigned:</b>	09/25/2014	<b>Date of Injury:</b>	09/28/2010
<b>Decision Date:</b>	11/24/2014	<b>UR Denial Date:</b>	08/25/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/23/2014

### 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 & Rehabilitation 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:

Patient is a 42-year-old male who has submitted a claim for cervical sprain / strain, cervical myofasciitis, cervical disc protrusion, lumbosacral sprain / strain, lumbar disc protrusion, gastritis, adjustment disorder with mixed anxiety disorder, and sleep disturbance associated with an industrial injury date of 09/28/2010. Medical records from 2013 to 2014 were reviewed. Patient complained of constant, moderate neck pain and back pain, rated 7/10 in severity. He likewise reported sleep disturbance and throbbing abdominal pain. Physical examination of the cervical spine showed decreased and painful range of motion, tenderness, muscle spasm, and positive cervical compression test. Shoulder depression test was positive bilaterally. Motor and reflexes were intact. Examination of the lumbar spine showed decreased and painful range of motion, tenderness, muscle spasm, positive Kemp's test, and positive straight leg raise test bilaterally. Sensation was diminished at the left upper and lower extremity. Urine drug screen from 7/30/2014 showed negative level of medications. Treatment to date has included home exercise program. Utilization review from 08/25/2014 denied the requests for X-ray of the lumbar spine, MRI of the lumbar spine, and EMG/NCV of bilateral upper extremities because of insufficient clinical information presented to support the request; denied medium back brace because patient was not in an acute postoperative setting to warrant such; denied Tramadol, Flexeril, Relafen, and Prilosec because the scant medical records did not support the clinical indication, the efficacy, and utility for any positive outcomes from medication use; denied Methoderm because of limited published studies concerning its efficacy and safety; and denied urine toxicology because of lack of indication.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**X-rays of lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back (Acute and Chronic)

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

**Decision rationale:** The CA MTUS ACOEM states that lumbar spine X-rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least six weeks. However, it may be appropriate when the physician believes it would aid in patient management. In this case, patient complained of constant, moderate back pain, rated 7/10 in severity. Examination of the lumbar spine showed decreased and painful range of motion, tenderness, muscle spasm, positive Kemp's test, and positive straight leg raise test bilaterally. Motor and reflexes were intact. Sensation was diminished at the left lower extremity. However, there was no documented rationale for radiographic imaging based on the records submitted. Given the date of injury (09/28/2010), it was unclear if x-ray had been performed in the past. There was likewise no new trauma to warrant such procedure. It was not clearly discussed how x-ray can affect treatment plans at this point. The medical necessity cannot be established due to insufficient information. Therefore, request for X-ray of the Lumbar Spine is not medically necessary.

**MRI of lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back (Acute & Chronic)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Section, MRI

**Decision rationale:** As stated on pages 303-304 of the ACOEM Practice Guidelines referenced by CA MTUS, imaging of the lumbar spine is recommended in patients with red flag diagnoses where plain film radiographs are negative; unequivocal objective findings that identify specific nerve compromise, failure to respond to treatment, and consideration for surgery. In addition, Official Disability Guidelines recommends MRI for the lumbar spine for uncomplicated low back pain, with radiculopathy, after at least 1 month of conservative therapy, sooner if severe, or progressive neurologic deficit. In this case, patient complained of constant, moderate back pain, rated 7/10 in severity. Examination of the lumbar spine showed decreased and painful range of motion, tenderness, muscle spasm, positive Kemp's test, and positive straight leg raise test bilaterally. Motor and reflexes were intact. Sensation was diminished at the left lower extremity. However, there was no documented rationale for MRI based on the records submitted. Given the

date of injury (09/28/2010), it was unclear if MRI had been performed in the past. It was not clearly discussed how it can affect treatment plans at this point. The medical necessity cannot be established due to insufficient information. Therefore, request for MRI of the lumbar spine is not medically necessary.

**EMG of left upper extremity:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back (Acute & Chronic)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 537.

**Decision rationale:** CA MTUS ACOEM Guidelines state that electromyography (EMG) studies may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. In this case, patient complained of constant, moderate neck pain, rated 7/10 in severity. Physical examination of the cervical spine showed decreased and painful range of motion, tenderness, muscle spasm, and positive cervical compression test. Shoulder depression test was positive bilaterally. Motor and reflexes were intact. Sensation was diminished at the left upper extremity. Clinical manifestations were not consistent with focal neurologic deficit to warrant EMG. Moreover, there was no documented rationale for EMG based on the records submitted. Given the date of injury (09/28/2010), it was unclear if EMG had been performed in the past. It was not clearly discussed how it can affect treatment plans at this point. The medical necessity cannot be established due to insufficient information. Therefore, the request for EMG of the left upper extremity is not medically necessary.

**EMG of right upper extremity:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back (Acute & Chronic)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 537.

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unclear if EMG had been performed in the past. It was not clearly discussed how it can affect treatment plans at this point. The medical necessity cannot be established due to insufficient information. Therefore, the request for EMG of the right upper extremity is not medically necessary.

**NCV of left upper extremity: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back (Acute & Chronic)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 261-262. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back, Nerve Conduction Studies Other Medical Treatment Guideline or Medical Evidence: Nerve Conduction Studies in Polyneuropathy: Practical Physiology and Patterns of Abnormality, Acta Neurol Belg 2006 Jun; 106 (2): 73-81

**Decision rationale:** CA MTUS ACOEM Guidelines state that appropriate electrodiagnostic studies may help differentiate between carpal tunnel syndrome and other conditions, such as cervical radiculopathy. These include nerve conduction studies, or in more difficult cases, electromyography may be helpful. Moreover, ODG states that NCS is not recommended to demonstrate radiculopathy if radiculopathy has already been clearly identified by EMG and obvious clinical signs, but is recommended if the EMG is not clearly consistent with radiculopathy. A published study entitled, "Nerve Conduction Studies in Polyneuropathy", cited that NCS is an essential part of the work-up of peripheral neuropathies. Many neuropathic syndromes can be suspected on clinical grounds, but optimal use of nerve conduction study techniques allows diagnostic classification and is therefore crucial to understanding and separation of neuropathies. In this case, patient complained of constant, moderate neck pain, rated 7/10 in severity. Physical examination of the cervical spine showed decreased and painful range of motion, tenderness, muscle spasm, and positive cervical compression test. Shoulder depression test was positive bilaterally. Motor and reflexes were intact. Sensation was diminished at the left upper extremity. Clinical manifestations were not consistent peripheral neuropathy to warrant NCV. Moreover, there was no documented rationale for NCV based on the records submitted. Given the date of injury (09/28/2010), it was unclear if NCV had been performed in the past. It was not clearly discussed how it can affect treatment plans at this point. The medical necessity cannot be established due to insufficient information. Therefore, the request for NCV of the left upper extremity is not medically necessary.

**NCV of right upper extremity: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back (Acute & Chronic)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 261-262. Decision based on Non-MTUS Citation Official Disability

Guidelines, Neck and Upper Back, Nerve Conduction Studies Other Medical Treatment  
Guideline or Medical Evidence: Nerve Conduction Studies in Polyneuropathy: Practical  
Physiology and Patterns of Abnormality, Acta Neurol Belg 2006 Jun; 106 (2): 73-81

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**Medium Back Brace:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back (Acute & Chronic)

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

**Decision rationale:** As stated on CA MTUS ACOEM Low Back Chapter, lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. In this case, patient complained of chronic back pain since the injury date of 2010. However, the request for a back brace as part of the conservative treatment regimen is outside the initial acute phase of injury and not supported by the guidelines. Therefore, the request for medium back brace is not medically necessary.

**Tramadol:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78.

**Decision rationale:** As stated on page 78 of CA MTUS Chronic Pain Medical Treatment Guidelines, there are 4 A's for ongoing monitoring of opioid use: pain relief, side effects, physical and psychosocial functioning and the occurrence of any potentially aberrant drug-related behaviors. The monitoring of these outcomes over time should affect therapeutic decisions and provide a framework for documentation of the clinical use of these controlled drugs. In this case, there is no progress report stating prescription for Tramadol. It is unclear if patient is currently on Tramadol given the injury date of 2010, or if there is a plan to initiate such treatment. The medical necessity cannot be established due to insufficient information. The request likewise failed to specify dosage and quantity to be dispensed. Therefore, the request for Tramadol is not medically necessary.

**Flexeril:** 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 Cyclobenzaprine Page(s): 41-42.

**Decision rationale:** According to page 41-42 of the CA MTUS Chronic Pain Medical Treatment Guidelines, sedating muscle relaxants are recommended with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. In this case, there is no progress report stating prescription for Flexeril. It is unclear if patient is currently on Flexeril given the injury date of 2010, or if there is a plan to initiate such treatment. The medical necessity cannot be established due to insufficient information. The request likewise failed to specify dosage and quantity to be dispensed. Therefore, the request for Flexeril is not medically necessary.

**Relafen:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 46.

**Decision rationale:** As stated on page 46 of the California MTUS Chronic Pain Medical Treatment guidelines, NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain and that there is no evidence of long-term effectiveness for pain or function. In this case, there is no progress report stating prescription for Relafen. It is unclear if patient is currently on Relafen given the injury date of 2010, or if there is a plan to initiate such treatment. The medical necessity cannot be established due to insufficient

information. The request likewise failed to specify dosage and quantity to be dispensed. Therefore, the request for Relafen is not medically necessary.

**Prilosec:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs and GI symptoms and cardiovascular risk.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI Symptoms, and Cardiovascular Risk Page(s): 68.

**Decision rationale:** As stated on page 68 of CA MTUS Chronic Pain Medical Treatment Guidelines, clinicians should weigh the indications for NSAIDs against both GI and cardiovascular risk factors: age > 65 years, history of peptic ulcer, GI bleeding or perforation; concurrent use of ASA, corticosteroids, or anticoagulant; or on high-dose/multiple NSAIDs. Patients with intermediate risk factors should be prescribed proton pump inhibitors (PPI). In this case, patient has been complaining of abdominal pain. Esophagogastroduodenoscopy with biopsy performed on 2/14/14 showed gastritis. The medical necessity for PPI use has been established. However, the request as submitted failed to specify dosage and quantity to be dispensed. The request is incomplete; therefore, the request for Prilosec is not medically necessary.

**Menthoderm:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Salicylates; Topical Analgesics Page(s): 105; 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Section, Topical Salicylates

**Decision rationale:** Page 111 of CA MTUS Chronic Pain Medical Treatment Guidelines state that topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. Menthoderm gel contains methyl salicylate and menthol. Regarding the Menthol component, CA MTUS does not cite specific provisions, but the ODG Pain Chapter states that the FDA has issued an alert in 2012 indicating that topical OTC pain relievers that contain menthol, or methyl salicylate, may in rare instances cause serious burns. Regarding the Methyl Salicylate component, CA MTUS states on page 105 that salicylate topicals are significantly better than placebo in chronic pain. In this case, Menthoderm gel was prescribed as adjuvant therapy to oral medications. However, the requested Menthoderm has the same formulation of over-the-counter products such as BenGay. It has not been established that there is any necessity for this specific brand name. There is no compelling indication for this request. Therefore, the request for Menthoderm is not medically necessary.

**Urine toxicology:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use Page(s): 78.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-going Management Page(s): 78.

**Decision rationale:** Page 78 of the CA MTUS Chronic Pain Medical Treatment Guidelines state that urine drug screens are recommended as an option to assess order use or presence of illegal drugs and as ongoing management for continued opioid use. Screening is recommended randomly at least twice and up to 4 times a year. In this case, there is no progress report providing a list of current medications. There is likewise no documented rationale for urine screening. Urine drug screen from 7/30/2014 showed negative level for any medication. There is no clear indication for repeat testing at this time. Therefore, the request for urine toxicology is not medically necessary.

**RTC 4-6 weeks:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Section, Office Visits

**Decision rationale:** The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Official Disability Guidelines, (ODG), Pain Chapter was used instead. It states that evaluation and management (E&M) outpatient visits to the offices of medical doctor play a critical role in the proper diagnosis and return to function of an injured worker, to monitor the patient's progress, and make any necessary modifications to the treatment plan. In this case, patient is monitored for constant, moderate neck pain and back pain. He likewise reported sleep disturbance and throbbing abdominal pain. Diagnostic tests and medications have been requested in this review. The medical necessity for a follow-up appointment has been established. However, the present request as submitted failed to indicate whether the patient will follow-up to his chiropractor or gastrointestinal specialist. The request is incomplete; therefore, the request for RTC 4 - 6 weeks is not medically necessary.