

<b>Case Number:</b>	CM14-0039954		
<b>Date Assigned:</b>	07/30/2014	<b>Date of Injury:</b>	11/25/2013
<b>Decision Date:</b>	09/09/2014	<b>UR Denial Date:</b>	03/18/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/04/2014

### 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 Internal 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 patient is an injured worker with diagnoses including cervical trapezial musculoligamentous sprain strain with associated bilateral upper extremity radiculitis, thoracic sprain strain, lumbar musculoligamentous sprain strain with associated left lower extremity radiculitis, left elbow medial and lateral Epicondylitis. The date of injury was 11/25/13. The injured worker's diagnoses include cervical and lumbar thoracic strains, left elbow Epicondylitis, and emotional symptoms with sleep difficulties due to the patient's orthopedic condition. The patient's initial evaluation report on 02/10/14 documented the patient's complaints of neck pain radiating to both upper extremities as well as pain to the upper mid-back, left elbow, and low back radiating to left lower extremity. The physician reviewed the patient's history of initial injury, which was a cumulative trauma injury and noted that overall the patient had multiple sprains, as well as left elbow medial and lateral Epicondylitis. The patient's conditions are related to cumulative trauma from 04-01-2006. The treatment options included chiropractic, acupuncture, and invasive pain management. Electrodiagnostic studies of the upper and lower extremities were recommended to assess for cervical and lumbar radiculopathy and sensory motor deficits and indicated consideration would be given thereafter for other further imaging studies. The medications Lidopro cream for neuropathic pain and Norflex for spasms were recommended. On physical examination the patient was noted to have decreased sensation of both upper extremities in a C6-7 pattern, decreased sensation of the left lower extremity in an L5-S1 pattern, and 4/5 weakness of the left wrist on extension and flexion and 4/5 weakness in the left tibial anterior. Primary treating physician's progress report (PR-2) dated 02-28-2014 documented subjective complaints of neck and back pain. The patient states he has had two sessions of acupuncture with no benefit, as well as two sessions of chiropractic, which provided temporary relief. He discontinued further chiropractic. He denies any EMG/NCS being done. He denies any prior MRIs. The patient

currently rates his neck pain as a 9/10 on the pain scale, which is throbbing and radiates down to his mid back. He states his pain is severe at times. He has numbness radiating down the left arm to the hand. He also reports low back pain which he rates a 9/10 on the pain scale. He reports pain and numbness radiation down the left leg to the ankle. He states sitting for longer than fifteen minutes increases his pain, lying down relieves the pain. He states his neck pain as worse than the back pain. He reports bilateral shoulder pain. In regards to medications, he is taking Tylenol two times a day, which helps with his pain temporarily and Norflex two times a day, which provides him approximately 10% relief. He takes Sertraline once daily which helps with his stress. The physical examination findings included sensation decreased to right C7 and C8 dermatomes; sensation decreased along left lower extremity in an L5, S1 dermatomal pattern; otherwise, sensation intact over right lower extremity; 4/5 muscle weakness in left wrist extension/flexion and left elbow extension, 4/5 muscle weakness of left tibialis anterior and in inversion and eversion; otherwise, in right lower extremity, no focal weakness. The diagnoses were cervical/trapezial musculoligamentous sprain/strain with associated bilateral upper extremity radiculitis; thoracic sprain/strain; lumbar musculoligamentous sprain/strain with associated left lower extremity radiculitis; left elbow medial and lateral epicondylitis; emotional symptoms and sleep difficulties stemming from ongoing orthopedic complaints and work stressors. The treatment plan included chiropractic at a frequency of 2x per week for 4 weeks. EMG/NCV of the bilateral upper extremities and lower extremities to assess for cervical and lumbar radiculopathy was requested. A patient questionnaire dated 02-10-2014 documented no prior x-ray of the spine. An electrodiagnostic consultation dated 03-17-2014 documented the patient's complaints of neck pain radiating to the bilateral upper extremities, left worse than right and lower back pain radiating to the bilateral lower extremities, left worse than right. He complains of numbness, tingling and weakness in the bilateral upper and lower extremities, left worse than right. There is no prior history of spine surgery. An electrodiagnostic impression was normal study. There is no electrodiagnostic evidence of focal nerve entrapment, cervical radiculopathy, lumbar radiculopathy or generalized peripheral neuropathy affecting the upper or lower limbs. An utilization review decision date was 03-18-2014.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**Orphenadrine Citrate 100mg, #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47-49, Chronic Pain Treatment Guidelines Orphenadrine (Norflex) Muscle relaxants Page(s): 63-65, 65. Decision based on Non-MTUS Citation FDA Prescribing Information Orphenadrine Citrate (Norflex) <http://www.drugs.com/pro/orphenadrine-extended-release-tablets.html> <http://www.drugs.com/monograph/norflex.html>.

**Decision rationale:** The Medical Treatment Utilization Schedule (MTUS) addresses muscle relaxants. The American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004), states that muscle relaxants seem no more effective than NSAIDs for treating

patients with musculoskeletal problems. Muscle relaxants may hinder return to function by reducing the patient's motivation or ability to increase activity. Table 3-1 states that muscle relaxants are not recommended. Chronic Pain Medical Treatment Guidelines (Page 63-66) addresses muscle relaxants. Muscle relaxants should be used with caution as a second-line option for short-term treatment. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. According to a review in American Family Physician, muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions. Orphenadrine Citrate (Norflex) has been reported in case studies to be abused for euphoria and to have mood elevating effects. FDA Prescribing Information states that Orphenadrine Citrate (Norflex) is indicated for acute musculoskeletal conditions. Orphenadrine has been chronically abused for its euphoric effects. The mood elevating effects may occur at therapeutic doses of Orphenadrine. Patient is an injured worker with diagnoses including cervical trapezial musculoligamentous sprain and strain with associated bilateral upper extremity radiculitis, thoracic sprain and strain, lumbar musculoligamentous sprain and strain with associated left lower extremity radiculitis, left elbow medial and lateral Epicondylitis. The patient's conditions are related to cumulative trauma from 04-01-2006. MTUS and ACOEM guidelines do not recommend the long-term use of muscle relaxants. FDA guidelines states that Orphenadrine Citrate (Norflex) is indicated for acute conditions. The medical records and MTUS, ACOEM, and FDA guidelines do not support the use of Orphenadrine Citrate (Norflex). Therefore, the request for Orphenadrine Citrate 100mg, #60 is not medically necessary.

**Lidopro topical ointment 4oz:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Capsaicin, topical NSAIDs Page(s): 111-113, 28-29, 70.

**Decision rationale:** The Medical treatment utilization schedule (MTUS) Chronic Pain Medical Treatment Guidelines addresses topical analgesics. Topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. There is little to no research to support the use of many of these agents. Besides Lidoderm, no other commercially approved topical formulation of Lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. Further research is needed to recommend topical Lidocaine for chronic neuropathic pain disorders other than post-herpetic neuralgia. Topical Lidocaine is not recommended for non-neuropathic pain. There is only one trial that tested 4% lidocaine for treatment of chronic muscle pain. The results showed there was no superiority over placebo. Lidocaine may be considered, only after there has been evidence of a trial of first-line therapy (tricyclic or SNRI anti-depressants or an AED such as Gabapentin or Lyrica). Capsaicin is only an option in patients who have not responded or are intolerant to other treatments. All NSAIDs have the U.S. Boxed Warning for associated risk of adverse cardiovascular events, including, MI, stroke, and new onset or worsening of pre-existing hypertension. NSAIDs can cause ulcers and bleeding in the stomach and intestines at any time during treatment (FDA Medication Guide). Use of NSAIDs may compromise renal function. FDA medication guide recommends lab monitoring of a CBC and chemistry profile (including liver and renal function tests). Routine

blood pressure monitoring is recommended. It is generally recommended that the lowest effective dose be used for all NSAIDs for the shortest duration of time. Lidopro contains capsaicin, lidocaine, menthol, and methyl salicylate. The patient questionnaire dated 02-28-2014 documented the patient's report that Lidopro did not help decrease pain or improve function. There is no documentation that the patient has not responded or is intolerant to other treatments. Progress reports for 02-10-2014 and 02-28-2014 do not document blood pressure measurements or laboratory tests. A progress report 02-10-2014 documented a history of high cholesterol, family history of hypertension. An Electrodiagnostic consultation dated 03-17-2014 reported a normal study, with no electrodiagnostic evidence of focal nerve entrapment, cervical radiculopathy, lumbar radiculopathy or generalized peripheral neuropathy affecting the upper or lower limbs. There was no documentation of post-herpetic neuralgia. The MTUS guidelines state that topical Lidocaine is not recommended for non-neuropathic pain. Per MTUS guidelines, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. MTUS guidelines and medical records do not support the medical necessity of topical Lidocaine, Capsaicin, or Methyl Salicylate, which are active ingredients in Lidopro. Therefore, the request for Lidopro topical ointment 4oz is not medically necessary.

**8 sessions of Chiropractic therapy two (2) sessions a week for four (4) weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 173, 181, Chronic Pain Treatment Guidelines Chiropractic treatment Manual therapy & manipulation Page(s): 30, 58-60.

**Decision rationale:** The Medical treatment utilization schedule (MTUS) Chronic Pain Medical Treatment Guidelines provides treatment parameters. The time to produce effect is 4 to 6 treatments. The treatment beyond 4-6 visits should be documented with objective improvement in function. 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 6 visits should document objective improvement functional improvement. Manipulation is a passive treatment. Time to produce effect is 4 to 6 treatments. Treatment beyond 4-6 visits should be documented with objective improvement in function. Per MTUS guidelines, chiropractic treatment, manual therapy and manipulation are not recommended for carpal tunnel syndrome, forearm, wrist, hand, ankle, foot, knee conditions. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 8 Neck and Upper Back Complaints states that physical manipulation for neck pain is an optional physical treatment method, early in care only. Cervical manipulation has not yet been studied in workers' compensation populations. There is insufficient evidence to support manipulation of patients with cervical radiculopathy. The patient is an injured worker with diagnoses including cervical trapezial musculoligamentous sprain strain with associated bilateral upper extremity radiculitis, thoracic sprain strain, lumbar musculoligamentous sprain strain with associated left lower extremity radiculitis, left elbow medial and lateral Epicondylitis. The request was for 8 chiropractic visits (2x4). MTUS treatment parameters recommends up to 6 treatments. Treatment beyond 6 visits should be documented with objective improvement in function. The request for 8 chiropractic visits

exceeds MTUS guideline recommendations. Therefore, the request for Chiropractic therapy two (2) sessions a week for four (4) weeks is not medically necessary.

**Norflex ER 100mg, #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47-49, Chronic Pain Treatment Guidelines Orphenadrine (Norflex) Muscle relaxants Page(s): 63-65, 65. Decision based on Non-MTUS Citation FDA Prescribing Information Orphenadrine Citrate (Norflex) <http://www.drugs.com/pro/orphenadrine-extended-release-tablets.html> <http://www.drugs.com/monograph/norflex.html>.

**Decision rationale:** The medical treatment utilization schedule (MTUS) addresses muscle relaxants. The American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004), states that muscle relaxants seem no more effective than NSAIDs for treating patients with musculoskeletal problems. Muscle relaxants may hinder return to function by reducing the patient's motivation or ability to increase activity. Table 3-1 states that muscle relaxants are not recommended. The Chronic Pain Medical Treatment Guidelines (Page 63-66) addresses muscle relaxants. Muscle relaxants should be used with caution as a second-line option for short-term treatment. Efficacy appears to diminish over time, and prolonged use of some medications in this class may lead to dependence. According to a review in American Family Physician, muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions. Norflex (Orphenadrine Citrate) has been reported in case studies to be abused for euphoria and to have mood elevating effects. FDA Prescribing Information states that Norflex (Orphenadrine Citrate) is indicated for acute musculoskeletal conditions. Orphenadrine has been chronically abused for its euphoric effects. The mood elevating effects may occur at therapeutic doses of Orphenadrine (Norflex). Patient is an injured worker with diagnoses including cervical trapezial musculoligamentous sprain and strain with associated bilateral upper extremity radiculitis, thoracic sprain and strain, lumbar musculoligamentous sprain and strain with associated left lower extremity radiculitis, left elbow medial and lateral Epicondylitis. The patient's conditions are related to cumulative trauma from 04-01-2006. MTUS and ACOEM guidelines do not recommend the long-term use of muscle relaxants. FDA guidelines states that Norflex (Orphenadrine Citrate) is indicated for acute conditions. The medical records and MTUS, ACOEM, and FDA guidelines do not support the use of Norflex (Orphenadrine Citrate). Therefore, the request for Norflex ER 100mg, #60 is not medically necessary.

**Lidopro cream:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics NSAIDs Page(s): 111-113, 28-29, 70.

**Decision rationale:** The medical treatment utilization schedule (MTUS) Chronic Pain Medical Treatment Guidelines addresses topical analgesics. Topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. There is little to no research to support the use of many of these agents. Besides Lidoderm, no other commercially approved topical formulation of Lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain. Further research is needed to recommend topical Lidocaine for chronic neuropathic pain disorders other than post-herpetic neuralgia. Topical Lidocaine is not recommended for non-neuropathic pain. There is only one trial that tested 4% lidocaine for treatment of chronic muscle pain. The results showed there was no superiority over placebo. Lidocaine may be considered, only after there has been evidence of a trial of first-line therapy (tricyclic or SNRI anti-depressants or an AED such as Gabapentin or Lyrica). Capsaicin is only an option in patients who have not responded or are intolerant to other treatments. All NSAIDs have the U.S. Boxed Warning for associated risk of adverse cardiovascular events, including, MI, stroke, and new onset or worsening of pre-existing hypertension. NSAIDs can cause ulcers and bleeding in the stomach and intestines at any time during treatment (FDA Medication Guide). Use of NSAIDs may compromise renal function. FDA medication guide recommends lab monitoring of a CBC and chemistry profile (including liver and renal function tests). Routine blood pressure monitoring is recommended. It is generally recommended that the lowest effective dose be used for all NSAIDs for the shortest duration of time. Lidopro contains capsaicin, lidocaine, menthol, and methyl salicylate. Patient questionnaire dated 02-28-2014 documented the patient's report that Lidopro did not help decrease pain or improve function. There is no documentation that the patient has not responded or is intolerant to other treatments. Progress reports for 02-10-2014 and 02-28-2014 do not document blood pressure measurements or laboratory tests. Progress report 02-10-2014 documented a history of high cholesterol, family history of hypertension. An electrodiagnostic consultation dated 03-17-2014 reported a normal study, with no electrodiagnostic evidence of focal nerve entrapment, cervical radiculopathy, lumbar radiculopathy or generalized peripheral neuropathy affecting the upper or lower limbs. There was no documentation of post-herpetic neuralgia. The MTUS guidelines state that topical Lidocaine is not recommended for non-neuropathic pain. Per MTUS guidelines, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. MTUS guidelines and medical records do not support the medical necessity of topical Lidocaine, Capsaicin, or Methyl Salicylate, which are active ingredients in Lidopro. Therefore, the request for Lidopro cream is not medically necessary.

**Electromyography (EMG) of the bilateral lower extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, EMGs (electromyography) and Nerve conduction studies (NCS).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305, 308-309. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM) 3rd Edition (2011) Bibliographic Source: Low back disorders. Hegmann KT, editor(s). Occupational medicine practice guidelines. Evaluation and management of common health problems and functional recovery in workers. 3rd

ed. Elk Grove Village (IL): American College of Occupational and Environmental Medicine (ACOEM); 2011. p. 333-796. Guideline.Gov.

**Decision rationale:** The medical treatment utilization schedule (MTUS) addresses electromyography (EMG). The American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Low Back Complaints states that EMG for clinically obvious radiculopathy is not recommended. ACOEM 3rd Edition states that electrodiagnostic studies, which must include needle EMG, are recommended where a CT or MRI is equivocal and there are ongoing pain complaints that raise questions about whether there may be a neurological compromise that may be identifiable (i.e., leg symptoms consistent with radiculopathy, spinal stenosis, peripheral neuropathy, etc.). Doctor's first report dated 02-10-2014 documented the diagnosis of lumbar musculoligamentous sprain/strain with left lower extremity radiculitis. The physical examination findings included muscle weakness in the left lower extremity, 4/5 left tibialis anterior and inversion and eversion, decreased sensation along left lower extremity in a L5-S1 dermatomal pattern, lumbosacral tenderness, and decreased range of motion. The medical records document a diagnosis of lumbar radiculopathy. The ACOEM guidelines state that EMG is not recommended for clinically obvious radiculopathy. The ACOEM guidelines indicate that CT or MRI should be performed before considering EMG. No MRI or CT results are documented in the medical records. MTUS and ACOEM guidelines and medical records do not support the medical necessity of EMG. Therefore, the request for Electromyography (EMG) of the bilateral lower extremities is not medically necessary.

**Nerve conduction velocity (NCV) study of the bilateral lower extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, EMGs (electromyography) and Nerve conduction studies (NCS).

**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, Lumbar & Thoracic (Acute & Chronic) Nerve conduction studies (NCS) Work Loss Data Institute. Bibliographic Source: Work Loss Data Institute. Low back -- lumbar & thoracic (acute & chronic). Encinitas (CA): Work Loss Data Institute; 2013 Dec 4. Guideline.Gov.

**Decision rationale:** The medical treatment utilization schedule (MTUS) does not address nerve conduction studies for low back conditions. Official Disability Guidelines (ODG) Low Back, Lumbar & Thoracic (Acute & Chronic) states that nerve conduction studies (NCS) are not recommended. The Work Loss Data Institute guidelines for the low back states that nerve conduction studies (NCS) are not recommended. A Doctor's first report dated 02-10-2014 documented the diagnosis of lumbar musculoligamentous sprain/strain with left lower extremity radiculitis. The physical examination findings included muscle weakness in the left lower extremity, 4/5 left tibialis anterior and inversion and eversion, decreased sensation along left lower extremity in a L5-S1 dermatomal pattern, lumbosacral tenderness, and decreased range of motion. The medical records document a diagnosis of lumbar radiculopathy. The ODG and Work Loss Data Institute guidelines do not recommend nerve conduction studies. Therefore, the

request for Nerve Conduction Velocity (NCV) study of the bilateral lower extremities is not medically necessary.