

<b>Case Number:</b>	CM14-0044018		
<b>Date Assigned:</b>	07/02/2014	<b>Date of Injury:</b>	03/25/2005
<b>Decision Date:</b>	09/16/2014	<b>UR Denial Date:</b>	01/14/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/07/2014

### 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 Occupational 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 a 54-year-old male who has submitted a claim for lumbar spine Intervertebral Disc (IVD) w/o myelopathy, thoracic sprain/strain, lumbar/lumbosacral neuritis, cervical myofascitis, spasm of muscles, post-op laminectomy, and anxiety associated with an industrial injury date of 03/25/2005. Medical records from 07/23/2013 to 07/02/2014 were reviewed and showed that patient complained of pain in posterior neck (graded 3/10) and upper (graded 4/10), right mid (graded 7/10), and right low back (graded 8/10) radiating down right lower extremity. Physical examination revealed decreased cervical and lumbar spine range of motion (ROM). Tenderness was noted over the lumbar region bilaterally. Manual Muscle Test (MMT) of lower extremities was normal. Straight Leg Raise (SLR) test was positive on the left side. Braggard's sign was positive on the right. Kemps test was positive bilaterally. Of note, patient was unable to do Home Exercise Program (HEP) due to pain (02/07/2014). Treatment to date has included laminectomy 08/11/2006 chiropractic therapy, acupuncture, extracorporeal shock wave therapy (ESWT), Norco 7.5mg TID (DOS: 1/13/2014), Tramadol 50mg BID (DOS: 07/23/2013), hydrocodone-acetaminophen 500mg OD (DOS: 07/23/2013), Prilosec 20 mg OD-BID (DOS: 07/23/2013), Anaprox, Gabapentin. Of noted Prilosec was prescribed for GI distress prophylaxis (07/23/2013). Utilization review dated 01/14/2014 denied the request for Prilosec 20mg #90 because there was no documentation of gastrointestinal disturbances or pathology. Utilization review dated 01/14/2014 denied the request for Tramadol 50mg #240 as there was no documentation of trials and failure of or intolerance to other more commonly used first line drugs. Utilization review dated 01/14/2014 denied the request for chiropractic treatment to include the following modalities EMS (Electronic Muscle Stimulation), Hydroculation, hot packs and diathermy for the lumbar spine (2x3) because there was no evidence that claimant was involved in an ongoing independent rehab program.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **EMS (ELECTRONIC MUSCLE STIMULATION), HYDROCULATION, HOT PACKS AND DIATHERMY FOR THE LUMBAR SPINE: 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 TENS Page(s): 114-116. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Cold/Heat Packs and Diathermy.

**Decision rationale:** According to CA MTUS Chronic Pain Treatment Guidelines, Transcutaneous Electrical Nerve Stimulation (TENS) is not recommended as a primary treatment modality. A trial of one-month home-based TENS may be considered as a noninvasive conservative option. It should be used as an adjunct to a program of evidence-based functional restoration. A one-month trial period of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function. Regarding hot packs, the CA MTUS does not address this topic specifically. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, the Official Disability Guidelines, (ODG), Low Back chapter, Cold/heat packs was used instead. The Official Disability Guidelines state that heat packs are recommended as an option for acute pain. At home, local applications of cold packs in the first few days of acute complaint; thereafter, applications of heat packs or cold packs are recommended. Regarding diathermy, ODG states that diathermy is not recommended as there is no proven efficacy in the treatment of acute low back symptoms. It has not been proven to be more effective than placebo diathermy or conventional heat therapy. The guidelines do not address hydroculation. In this case, the patient complained of chronic posterior neck and back pain. Objective findings did not reveal evidence of acute exacerbation, which is a requirement to support use of hot packs. The patient was noted to be unable to do Home Exercise Program (HEP) (02/07/2014). It is unclear as to whether the patient is actively participating in a functional rehabilitation program. The guidelines only recommend TENS as an adjunct to functional rehabilitation program. Moreover, the guidelines do not recommend diathermy for low back pain as it is not proven to be superior over conventional heat therapy. Therefore, the request for EMS (Electronic Muscle Stimulation), hydroculation, hot packs and diathermy for the lumbar spine is not medically necessary.

### **PRILOSEC 20 MG ( # 90): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS Page(s): 68, 115, 116.

**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 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 started with proton pump inhibitor. In this case, the patient was prescribed Prilosec 20mg #90 since 07/23/2013 as prophylaxis against GI distress. There was no documentation of gastrointestinal disturbances or pathology. The patient is not at intermediate risk for GI events. Therefore, the request for Prilosec 20 MG (# 90) is not medically necessary.

**TRAMADOL 50 MG (#240):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines OPIOIDS Page(s): 80, 82, 84, 89, 93, 95, 89, 15, 116.

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

**Decision rationale:** As noted on page 78 of the Chronic Pain Medical Treatment Guidelines, there is no support for ongoing opioid treatment unless there is ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. These outcomes over time should affect the therapeutic decisions for continuation. In this case, the patient was prescribed Tramadol 50mg since 07/23/2013. There has been no documentation of pain relief or functional improvement, which is required to support continuation of Tramadol use. Furthermore, there was no documentation of urine toxicology review. Therefore, the request for Tramadol 50 MG (#240) is not medically necessary.