

<b>Case Number:</b>	CM14-0201664		
<b>Date Assigned:</b>	01/14/2015	<b>Date of Injury:</b>	12/30/2013
<b>Decision Date:</b>	02/20/2015	<b>UR Denial Date:</b>	11/14/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/01/2014

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: California  
 Certification(s)/Specialty: Physical Medicine & Rehabn

### CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This patient presents with right sided neck pain, right mid back pain, right low back pain and right knee pain. The current request is for ADDITIONAL 12 SESSIONS OF PHYSICAL THERAPY. For physical medicine, the MTUS Guidelines page 98 and 99 recommends for myalgia, myositis, and neuritis-type symptoms, 9 to 10 sessions over 8 weeks. Review of the medical files documents that this patient participated in 12 physical therapy sessions between 7/23/14 and 10/17/14. Progress physical therapy report dated 8/22/14 notes that "HEP was updated with additional exercises." Additional PT sessions were recommended to "keep her symptoms under control." In this case, there is no rationale provided to indicate why the patient is not able to transition into a self-directed home exercise program. In addition, there is no new report of new injury, new surgery or new diagnoses that substantiate the current request for additional sessions. The patient has participated in 12 sessions, and the requested additional 12 sessions exceeds MTUS recommendation for 9 to 10 sessions. The requested additional PT is not medically necessary.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI w/o contrast for lumbar spine:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back chapter, MRIs (Magnetic Resonance Imaging)

**Decision rationale:** ACOEM guidelines, Chapter 12, page 303 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." For chronic pain, ODG guidelines, Low back chapter, MRIs (magnetic resonance imaging) (L-spine): "Indication for imaging for uncomplicated low back pain with radiculopathy recommends at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit. MRI is also recommended if there is a prior lumbar surgery." Treating physician requests MRI of the lumbar spine for further evaluation. UR letter dated 11/14/14 states "the patient has no radicular findings..." However, per progress report dated 10/07/14, the patient presents with back pain that radiates down the right hip and thigh, and cramping in the groin; which are radicular symptoms. Patient also has a diagnosis of discogenic lumbar condition with facet inflammation. There is no record of prior lumbar MRI in review of medical records, and symptoms persist despite conservative care. The request is reasonable and in line with guideline indications. Therefore, lumbar MRI IS medically necessary.

**MRI w/o contrast for cervical spine:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177-178. 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): 177-178. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic) chapter, Magnetic Resonance Imaging (MRI)

**Decision rationale:** Regarding MRI, uncomplicated Neck pain, chronic neck pain, ACOEM Chapter: 8, pages 177-178 states: "Neck and Upper Back Complaints, under Special Studies and Diagnostic and Treatment Considerations: Physiologic evidence of tissue insult or neurologic dysfunction. It defines physiologic evidence as form of "definitive neurologic findings on physical examination, electrodiagnostic studies, laboratory tests, or bone scans." ACOEM further states that unequivocal findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging studies if symptoms persist." ODG Guidelines, Neck and Upper Back (Acute & Chronic) chapter, Magnetic resonance imaging (MRI) states: "Not recommended except for indications list below. Indications for imaging --MRI (magnetic resonance imaging):- Chronic neck pain (after 3 months conservative treatment), radiographs normal, neurologic signs or symptoms present- Neck pain with radiculopathy if severe or progressive neurologic deficit". Treating physician requests MRI of the cervical spine

for further evaluation. UR letter dated 11/14/14 states "there is no indication of subjective or objective findings consistent with injury or neurologic dysfunction related to the cervical spine..." However, per progress report dated 10/07/14, the patient presents with arm weakness, tingling and numbness in fingers; which are radicular symptoms indicating neurologic dysfunction. Patient also has a diagnosis of discogenic cervical condition with facet inflammation. There is no record of prior cervical MRI in review of medical records, and symptoms persist despite conservative care. The request is reasonable and in line with guideline indications. Therefore, lumbar MRI IS medically necessary.

**Cervical traction with air bladder:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back (Acute & Chronic)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and Upper Back (Acute & Chronic) Chapter, under Traction (mechanical).

**Decision rationale:** ACOEM guidelines page 173 on C-spine traction states, "There is no high-grade scientific evidence to support the effectiveness or ineffectiveness of passive physical modalities such as traction. These palliative tools may be used on a trial basis but should be monitored closely. Furthermore, page 181 ACOEM lists "traction" under "Not Recommended" section for summary of recommendations and evidence table 8-8. ODG-TWC, Neck and Upper Back (Acute & Chronic) Chapter, under Traction (mechanical) states: "Cervical traction can provide symptomatic relief in over 80% of patients with mild to moderately severe (Grade 3) cervical spinal syndromes with radiculopathy." Per progress report dated 10/07/14, the patient presents with arm weakness, tingling and numbness in fingers; which are radicular symptoms indicating neurologic dysfunction. Patient also has a diagnosis of discogenic cervical condition with facet inflammation. ODG guidelines support patient controlled traction units for radiculopathy with mild to moderately severe (Grade 3) cervical spinal syndromes. However, treating physician has not documented radiculopathy for which cervical traction may be tried. Therefore, the request IS NOT medically necessary.

**TENS unit 4 lead:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines the criteria for the use of TENS Page(s): 116.

**Decision rationale:** According to MTUS Chronic Pain Management Guidelines the criteria for the use of TENS in chronic intractable pain:(p116) "a one-month trial period of the TENS unit should be documented (as an adjunct to other 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 during this trial." Per progress report dated 12/04/14, the patient has been authorized for right shoulder surgery, and treating physician is requesting in-home TENS unit. MTUS requires documentation of one month trial prior to dispensing home units, as an adjunct to other treatment modalities, within a functional restoration approach. Furthermore, the patient does not present with an indication for TENS unit. MTUS supports TENS units for neuropathic pain, spasticity, MS, phantom pain, and others; but not chronic low back or neck pain. Treating physician has not discussed how the TENS is to be used, either. Therefore, the request IS NOT medically necessary.

**Cyclobenzaprine 7.5mg tab #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants (for pain) Page(s): 63-66.

**Decision rationale:** MTUS pgs. 63-66 states: "Muscle relaxants (for pain): Recommend non-sedating muscle relaxants with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic LBP. The most commonly prescribed antispasmodic agents are carisoprodol, cyclobenzaprine, metaxalone, and methocarbamol, but despite their popularity, skeletal muscle relaxants should not be the primary drug class of choice for musculoskeletal conditions." For Skelaxin, MTUS p.61 states, "Recommended with caution as a second-line option for short-term pain relief in patients with chronic LBP. Metaxalone (marketed by King Pharmaceuticals under the brand name Skelaxin) is a muscle relaxant that is reported to be relatively non-sedating." Per progress report dated 12/04/14, the patient has been authorized for right shoulder surgery, and treating physician is requesting Flexeril for muscle spasms. MTUS recommends Cyclobenzaprine for short-term use. Flexeril was prescribed in progress report dated 12/04/14, quantity unspecified. Though patient is anticipating surgery, patient has already used Cyclobenzaprine beyond recommended indication. Furthermore, the current request for quantity 60 indicates intended long-term use of this medication. Therefore, the request IS NOT medically necessary.

**Gabapentin 600mg #90:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin Page(s): 18, 19.

**Decision rationale:** MTUS has the following regarding Gabapentin on pgs. 18, 19: "Gabapentin (Neurontin, Gabarone, generic available) has been shown to be effective for treatment of diabetic painful neuropathy and postherpetic neuralgia and has been considered as a first-line treatment for neuropathic pain." MTUS p60 also states, "A record of pain and function with the medication should be recorded," when medications are used for chronic pain. Per

progress report dated 12/04/14, the patient has been authorized for right shoulder surgery, and treating physician is requesting Neurontin for postoperative neuropathic pain. Patient presents with neuropathic pain for which Gabapentin is indicated, and is anticipating surgery. The request appears reasonable, therefore it IS medically necessary.

**Pantoprazole 20mg #60: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms and Cardiovascular Risk Page(s): 69.

**Decision rationale:** Regarding NSAIDs and GI/CV risk factors, MTUS requires determination of risk for GI events including age >65; history of peptic ulcer, GI bleeding or perforation; concurrent use of ASA, corticosteroids, and/or an anticoagulant; or high dose/multiple NSAID. MTUS pg. 69 states "NSAIDs, GI symptoms and cardiovascular risk: Treatment of dyspepsia secondary to NSAID therapy: Stop the NSAID, switch to a different NSAID, or consider H2-receptor antagonists or a PPI." Per progress report dated 12/04/14, the patient has been authorized for right shoulder surgery, and treating physician is requesting Protonix for upset stomach. Patient has been prescribed Tylenol in the past. However, in review of medical records, patient is not on NSAID therapy to warrant prophylactic use of PPI, and there is no GI risk assessment as required by MTUS. Therefore the request IS NOT medically necessary.

**20 Terocin patches: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm Patches; Topical Creams; Topical Analgesics Page(s): 56, 57, 111, 113.

**Decision rationale:** MTUS guidelines page 57 states, "topical lidocaine may be recommended for localized peripheral pain 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)." MTUS Page 112 also states, "Lidocaine Indication: Neuropathic pain; recommended for localized peripheral pain." When reading ODG guidelines, it specifies that Lidoderm patches are indicated as a trial if there is "evidence of localized pain that is consistent with a neuropathic etiology." ODG further requires documentation of the area for treatment, trial of a short-term use with outcome documenting pain and function. Per progress report dated 12/04/14, the patient has been authorized for right shoulder surgery, and treating physician is requesting Terocin patches for topical relief. Treating physician does he discuss how it is used with what efficacy. The patient presents with low back, neck and shoulder pain. MTUS supports the use of these patches for neuropathic pain that is peripheral and localized, which patient does not present with. Therefore, the request IS NOT medically necessary.

**Tramadol 150mg #30:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for Use of Opioids Page(s): 76-78, 88, 89.

**Decision rationale:** MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. Per progress report dated 12/04/14, the patient has been authorized for right shoulder surgery, and treating physician is requesting Tramadol for pain. Tramadol has been prescribed in progress report dated 10/07/14. Treating physician has not appropriately addressed the 4A's as required by guidelines. However, the patient has been able to work his regular duties. It appears this request is for anticipated surgery for the right shoulder. The request IS medically necessary and reasonable to cover post-operative shoulder pain.

**LidoPro lotion 4 ounces:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Creams; Topical Analgesics Page(s): 111.

**Decision rationale:** The MTUS has the following regarding topical creams (p111, chronic pain section): "Topical Analgesics: Recommended as an option as indicated below. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Topical lidocaine, in the formulation of a dermal patch (Lidoderm) has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain." Per progress report dated 12/04/14, the patient has been authorized for right shoulder surgery, and treating physician is requesting LidoPro for topical relief. MTUS page 111 states that if one of the compounded topical products is not recommended, then the entire product is not. In this case, the requested topical compound contains Lidocaine, which is not supported for topical use in lotion form per MTUS. Therefore, the request IS NOT medically necessary.