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| <b>Case Number:</b>   | CM14-0208392 |                              |            |
| <b>Date Assigned:</b> | 12/22/2014   | <b>Date of Injury:</b>       | 10/15/2013 |
| <b>Decision Date:</b> | 02/17/2015   | <b>UR Denial Date:</b>       | 11/25/2014 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 12/12/2014 |

### 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, has a subspecialty in Interventional Spine 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 42 year old male with an injury date of 10/15/13. Per physician's progress report dated 09/12/14, the patient complains of achy, stabbing, shooting, pain in the lower back that radiates to the right lower extremity. The pain is rated at 6-10/10 with an average of 9/10. Rest, medication and therapy alleviate the pain while physical activity aggravates it. The patient also reports some difficulty in activities of daily living. Physical examination reveals tenderness and hypertonicity in bilateral paravertebral muscles. The lumbar range of motion is limited and the Kemp's test is positive bilaterally. Progress report dated 08/04/14 reveals grade 2 tenderness to palpation in the paraspinal musculature along with a positive straight leg raise bilaterally. In progress report dated 05/13/14, the patient reports numbness and tingling in the right leg. The patient has been experiencing anxiety, stress and depression, as per the same report. The patient has received physical therapy and chiropractic treatment for his pain, as per progress report dated 09/12/14. He is using OTC Tylenol and topical creams for pain relief. The patient has also attended six sessions of shockwave therapy, as per the same progress report. The patient is currently not working, as per progress report dated 09/12/14. MRI of the Lumbar Spine, 02/03/14, as per progress report dated 05/13/14: - 2 mm disc protrusion at L4-5- 1mm disc protrusion at L3-4 and L5-S1 Diagnoses, 09/12/14:- Lumbar sprain/strain- Lumbar disc protrusion- Lumbar radiculopathy- Idiopathic peripheral autonomic neuropathy- Unspecific disorder of the autonomic nervous system The treater is requesting for (a) TEROGIN PATCH BOX OF 20 (b) ██████████ NARCOTIC TEST (c) SLEEP DISORDERED BREATHING / RESPIRATORY STUDY (PULSE OXIMETRY AND NASAL FUNCTION) 2 NIGHTS (d) CARDIO-RESPIRATORY / AUTONOMIC FUNCTION ASSESSMENT EVERY 3 MONTHS (e) MENTHODERM GEL 120 gm (f) HYDROCODONE /APAP 5/325 mg # 30 (g)

ACUPUNCTURE 2 X / WEEK FOR 4 WEEKS. The utilization review determination being challenged is dated 11/25/14. Treatment reports were provided from 05/13/14 - 09/12/14.

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

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

#### **Terocin Patch Box of 20: Overturned**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 49, Chronic Pain Treatment Guidelines Topical Analgesics.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Lidoderm (lidocaine patch). Lidocaine. Page(s): 56-57, 112. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) chapter Pain (Chronic), Lidoderm (Lidocaine patch).

**Decision rationale:** The patient presents with achy, stabbing, shooting, pain in the lower back that radiates to the right lower extremity. The pain is rated at 6-10/10 with an average of 9/10, as per progress report dated 09/12/14. The request for TEROGIN PATCH BOX OF 20. 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 (tri-cyclic 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, chapter 'Pain (Chronic)' and topic 'Lidoderm (Lidocaine patch)', 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. In this case, the prescription for Terocin patch was only noted in the latest progress report dated 09/12/14. The treater has prescribed the patch for "the treatment of minor aches and muscle pains." The patient has been diagnosed with Idiopathic peripheral autonomic neuropathy, as per the the same progress report. Both ODG and MTUS guidelines support the use of Lidocaine patch for peripheral neuropathy. Hence, this request IS medically necessary.

#### **██████ Narcotic Test: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Pain Chapter

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

**Decision rationale:** The patient presents with achy, stabbing, shooting, pain in the lower back that radiates to the right lower extremity. The pain is rated at 6-10/10 with an average of 9/10, as per progress report dated 09/12/14. The request for ████████ NARCOTIC TEST. ODG Guidelines, Pain (Chronic) chapter, Genetic testing for potential opioid abuse, state that genetic testing is "Not recommended. While there appears to be a strong genetic component to addictive

behavior, current research is experimental in terms of testing for this. Studies are inconsistent, with inadequate statistics and large phenotype range. Different studies use different criteria for definition of controls. More work is needed to verify the role of variants suggested to be associated with addiction and for clearer understanding of their role in different populations." In this case, a prescription for Tramadol (an opioid) was noted in progress report dated 05/13/14. The patient also received topical formulations with Tramadol in progress reports dated 07/08/14 and 08/04/14. In the latest progress report dated 09/12/14, the treater requests of Hydrocodone. In the same progress report, the treater also requests for genetic testing for opioid abuse "to improve patient's outcome and contain or avoid costs from unnecessary high dosage narcotic usage." A review of the available reports indicates that the patient is undergoing urine drug screens on a regular basis. Additional genetic testing for opioid abuse is not supported by ODG guidelines due to lack of consistent studies and adequate statistics. Hence, this request IS NOT medically necessary.

### **Sleep Disordered Breathing/Respiratory Study (Pulse oximetry and Nasal Function) 2**

**Nights:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Pain Chapter

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

**Decision rationale:** The patient presents with achy, stabbing, shooting, pain in the lower back that radiates to the right lower extremity. The pain is rated at 6-10/10 with an average of 9/10, as per progress report dated 09/12/14. The request for SLEEP DISORDERED BREATHING / RESPIRATORY STUDY (PULSE OXIMETRY AND NASAL FUNCTION) 2 NIGHTS. ODG-TWC guidelines, chapter 'Pain (chronic)' and topic 'Polysomnography', list the following criteria for Polysomnography: "Polysomnograms / sleep studies are recommended for the combination of indications listed below: (1) Excessive daytime somnolence; (2) Cataplexy (muscular weakness usually brought on by excitement or emotion, virtually unique to narcolepsy); (3) Morning headache (other causes have been ruled out); (4) Intellectual deterioration (sudden, without suspicion of organic dementia); (5) Personality change (not secondary to medication, cerebral mass or known psychiatric problems); & (6) Insomnia complaint for at least six months (at least four nights of the week), unresponsive to behavior intervention and sedative/sleep-promoting medications and psychiatric etiology has been excluded. A sleep study for the sole complaint of snoring, without one of the above mentioned symptoms, is not recommended." In this case, the patient suffers from chronic low back pain. A sleep disordered breathing/respiratory study report, dated 10/01/14 (after the progress report with the request) was provided for review. It indicated that the patient suffers from moderate pathological sleep breathing respiratory disorder. Hence, this appears to be a retrospective request. In a prior progress report dated 05/13/14, the treater states that the patient is having "sleep disturbances with 5-6 hours of interrupted sleep experienced each night, secondary to the physical pain that he is experiencing." The patient wakes up regularly at night and is unable to go back to sleep. As a result, he is experiencing "reduced daytime alertness," as per the same report. In progress report

dated 09/12/14, the patient's Epworth Sleepiness Scale is indicated as 5 out of 24. It is evident based on these clinical findings that the patient was having chronic sleep issues, as required by ODG guidelines. Hence, this request WAS medically necessary.

**Cardio-Respiratory/Autonomic Function Assessment Every 3 Months: Overturned**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines; Pain Chapter, Clinical Policy Bulletin: Autonomic Testing/Sudomotor Tests

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Aetna, Clinical Policy Bulletin: Cardiopulmonary Exercise Testing and Number: 0825

**Decision rationale:** The patient presents with achy, stabbing, shooting, pain in the lower back that radiates to the right lower extremity. The pain is rated at 6-10/10 with an average of 9/10, as per progress report dated 09/12/14. The request for CARDIO-RESPIRATORY / AUTONOMIC FUNCTION ASSESSMENT EVERY 3 MONTHS. Aetna, Clinical Policy Bulletin: Cardiopulmonary Exercise Testing and Number: 0825, considers cardiopulmonary exercise testing (CPET) medically necessary "after performance of standard testing, including echocardiography, and pulmonary function testing with measurement of diffusion capacity and measurement of oxygen desaturation (6-minute walk test).. "In this case, the patient does not suffer from any cardio-pulmonary conditions, as per progress report dated 09/12/14. In the same progress report, the treater requests for cardio-respiratory testing/ autonomic function assessment every three months. The treater, however, does not discuss the specific reason for this request. Additionally, cardio-respiratory testing every 3 months without any risk factors appears excessive. However, cardio-respiratory / autonomic function assessment report dated 09/12/14 (same date as the progress report with the request) was provided for review. The report indicated that the at least one of the two resting autonomic parameters of the patient is low and the patient needs further testing and evaluation. Given the results of this report, this request IS medically necessary.

**Menthoderm Gel 120gm: 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 NSAIDs. Page(s): 111.

**Decision rationale:** The patient presents with achy, stabbing, shooting, pain in the lower back that radiates to the right lower extremity. The pain is rated at 6-10/10 with an average of 9/10, as per progress report dated 09/12/14. The request for MENTHODERM GEL 120 gm .Menthoderm gel contains Methyl salicylate and Menthol. Regarding topical NSAIDs MTUS page 111 states, "Indications: Osteoarthritis and tendinitis, in particular, that of the knee and elbow or other joints

that are amenable to topical treatment." There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip or shoulder. Neuropathic pain: Not recommended as there is no evidence to support use." In this case, a prescription for Mentherm gel is only seen in progress report dated 09/12/14. The treater prescribes it for "temporary relief of minor aches and pains." However, there is no evidence of osteoarthritis or tendinitis of peripheral joints in this patient. He has, in fact, been diagnosed with neuropathic pain for which Mentherm gel is not indicated by MTUS. This request IS NOT medically necessary.

**Hydrocodone/APAP 5-325mg #30: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS. Medication for chronic pain Page(s): 88 and 89, 76-78, 60-61.

**Decision rationale:** The patient presents with achy, stabbing, shooting, pain in the lower back that radiates to the right lower extremity. The pain is rated at 6-10/10 with an average of 9/10, as per progress report dated 09/12/14. The request for HYDROCODONE /APAP 5/325 mg # 30. 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. In this case, the first prescription for Hydrocodone is seen in progress report dated 09/12/14. However, an earlier progress report dated 05/13/14 documents a prescription for Tramadol (another opioid), indicating that the patient has been on opioid therapy for several months. Nonetheless, the treater does not document a specific change in pain scale or improvement in function. Progress report dated 09/12/14 indicates that the patient will be undergoing urine drug screen during the visit but no CURES reports are discussed in the progress reports. The treater does not document side effects of opioid therapy as well. All four A's must be addressed for chronic opiate use. The request for Hydrocodone IS NOT medically necessary.

**Acupuncture 2x/week for 4 weeks: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Acupuncture 9792.24.1. Acupuncture Medical Treatment Guidelines. Page(s): 13,8.

**Decision rationale:** The patient presents with achy, stabbing, shooting, pain in the lower back that radiates to the right lower extremity. The pain is rated at 6-10/10 with an average of 9/10, as per progress report dated 09/12/14. The request for ACUPUNCTURE 2 X / WEEK FOR 4

WEEKS. For acupuncture, the MTUS Guidelines page 8 recommends acupuncture for pain, suffering, and for restoration of function. Recommended frequency and duration is 3 to 6 treatments for trial, and with functional improvement, 1 to 2 per month. For additional treatment, the MTUS Guidelines requires functional improvement as defined by Labor Code 9792.20(e) a significant improvement in ADLs, or change in work status and AND reduced dependence on medical treatments. A review of the available progress reports indicates that the patient has not received any acupuncture sessions in the past. He is suffering from chronic pain and has tried physical therapy and chiropractic treatments in the past, as per progress report dated 09/12/14. The available reports do not document a reason for this request. Furthermore, the requested 8 sessions exceeds what is allowed by MTUS for a trial. The request IS NOT medically reasonable.