

<b>Case Number:</b>	CM14-0211350		
<b>Date Assigned:</b>	02/06/2015	<b>Date of Injury:</b>	08/12/2014
<b>Decision Date:</b>	04/08/2015	<b>UR Denial Date:</b>	11/26/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/17/2014

### 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 & Rehabilitation

### 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 injured worker is a 30-year-old male who sustained an industrial injury on 08/12/2014. Diagnoses include cervical spine strain/sprain, bilateral shoulder strain/sprain rule out internal derangement, bilateral wrist pain rule out carpal tunnel syndrome, thoracic spine pain, thoracic spine strain/sprain rule out herniated nucleus pulposus, low back pain, lumbar strain/sprain rule out herniated nucleus pulposus, and rule out lumbar radiculopathy. Recent diagnostic testing has included x-rays of the bilateral wrist; bilateral shoulders; cervical spine; lumbar spine and thoracic spine. Prior treatments included massage therapy, heat and cold packs, and chiropractic therapy. Physician progress note of 10/10/2014, reports the injured worker complains of neck pain with spasms with numbness and tingling in the bilateral upper extremities; bilateral shoulder pain with radiation to bilateral arms; bilateral wrist pain associated with numbness and tingling of bilateral hands; mid- back pain with muscle spasms and low back pain associated with numbness and tingling in the bilateral lower extremities. On 11/26/2014 Utilization Review non-certified the following requested treatments; Retrospective x-rays of the thoracic spine; request for compound medications (Ketoprofen 20% 165gms, cyclobenzaprine 5% 100gm); request for cyclobenzaprine; request for Tabradol; request for Synapryn; request for Fanatrex; request for Deprizine; request for Dicopanol; request for functional capacity evaluation (FCE); request for hot/cold unit; request for TENS unit for home use; request for EMG/NCV of bilateral upper extremities and additional request for MRI of the cervical spine; request for EMG/NCV of bilateral lower extremities and request for MRI of lumbar spine; request for MRI of the lumbar spine; request for MRI of the thoracic spine; request for trigger point impedance imaging (TPII)

and LINT of the thoracic spine, ESWT to the lumbar/cervical/thoracic spine, bilateral shoulders and wrist (1x12); request for Physical Therapy to bilateral wrists, bilateral shoulders, cervical/thoracic/lumbar spine (3x6); request for Acupuncture for bilateral wrists (3x6); request for 18 acupuncture to the right and left shoulders (3x6); request for Acupuncture to the cervical/thoracic/lumbar spines (3x6). On 12/17/2014, an application for IMR was submitted.

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

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

#### **X-rays of the Thoracic Spine (provided on October 22, 2014): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter.

**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) Chapter, Radiography (x-rays).

**Decision rationale:** The ODG-TWC, Low Back - Lumbar & Thoracic (Acute & Chronic) Chapter under Radiography (x-rays) states: "Not recommend routine x-rays in the absence of red flags. (See indications list below.) Indications for imaging Plain X-rays: Thoracic spine trauma: severe trauma, pain, no neurological deficit; Thoracic spine trauma: with neurological deficit." In this case, the progress reports do not document prior x-ray of the thoracic spine. While the request is noted in progress report dated 10/16/14, the treating physician does not discuss the reason for the request. The patient has been diagnosed with thoracic spine pain, thoracic spine HNP, and thoracic spine sprain/strain. However, physical examination of the thoracic spine is unremarkable. ODG guidelines do not recommend radiography to patients with back pain in the absence of red flags, severe trauma pain or neurological deficit, which have not been mentioned. The request does not meet guideline indications. Therefore, the request is not medically necessary.

#### **Deprizine: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Library of Medicine's PubMed Database ([www.ncbi.nlm.nih.gov/pubmedhealth/PMH0000094/](http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0000094/)).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 69.

**Decision rationale:** The ACOEM and ODG Guidelines do not specifically discuss Deprizine. However, the Chronic Pain Medical Treatment Guidelines recommends determining risk for GI events before prescribing prophylactic PPI or omeprazole. GI risk factors include: (1) Age is greater than 65, (2) History of peptic ulcer disease and GI bleeding or perforation, (3) Concurrent use of ASA or corticosteroid and/or anticoagulant, (4) High dose/multiple NSAID. Deprizine has

been dispensed per treating physician reports dated 10/16/14 and 10/28/14. It is not known when the medication has been initiated. Per progress report dated 10/28/14, treating physician states "Deprizine contains ranitidine and other proprietary ingredients. Many patients who are on an oral NSAID to treat acute or chronic pain are at risk for gastrointestinal perforation/hemorrhage." Progress notes do not indicate that this patient suffers from any significant GI complaints, nor is he currently taking high dose or multiple NSAIDs. Routine prophylactic use of PPI without documentation of gastric issues is not supported by the guidelines without GI-risk assessment. Furthermore, treating physician has not indicated quantity, nor duration of this medication. The request is not in accordance with guidelines. Therefore, Deprizine is not medically necessary.

**Dicopanol:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation website Drugs.com.

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

**Decision rationale:** The MTUS, ACOEM, and ODG guidelines do not discuss Dicopanol. The ODG-TWC, Pain Chapter under Insomnia has the following regarding anti-Histamine for insomnia: (4) Over-the-counter medications: Sedating antihistamines have been suggested for sleep aids (for example, diphenhydramine). Tolerance seems to develop within a few days. Next-day sedation has been noted as well as impaired psychomotor and cognitive function. Side effects include urinary retention, blurred vision, orthostatic hypotension, dizziness, palpitations, increased liver enzymes, drowsiness, dizziness, grogginess and tiredness. ODG states that tolerance develops within a few days and long-term use is not supported. Dicopanol has been dispensed per treating physician reports dated 10/16/14 and 10/28/14. It is not known when this medication was initiated. Per progress report dated 10/28/14, treating physician quotes black box indications "Dicopanol contains diphenhydramine and other proprietary ingredients. It is widely used in many non-prescription sleep aids and cold medications for many years. It has been shown to be effective in the treatment of mild to moderate insomnia." The treating physician has not provided a discussion for the request. It appears this medication is being prescribed for the treatment of patient's insomnia secondary to chronic pain, which has not been documented. However, long-term use is not supported by guidelines, since tolerance develops within a few days. Furthermore, treating physician has not indicated quantity, nor duration of this medication. The request is not in accordance with guidelines. Therefore, Dicopanol is not medically necessary.

**Fantarex:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 18 - 19. Decision based on Non-MTUS Citation National Library of Medicine.

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

**Decision rationale:** Fanatrex contains Gabapentin and other proprietary ingredients. The Chronic Pain Medical Treatment Guidelines has the following regarding Gabapentin; Gabapentin has been shown to be effective for treatment of diabetic painful neuropathy and post-therapeutic neuralgia and has been considered a first-line treatment for neuropathic pain." Fanatrex has been dispensed per treating physician reports dated 10/16/14 and 10/28/14. It is not known when this medication was initiated. Per progress report dated 10/28/14, treating physician states, "Fanatrex contains Gabapentin and tricyclic antidepressants are considered as a first-line treatment option for neuropathic pain. Gabapentin has also been shown to be well tolerated." It appears treating physician has quoted black box indications without providing a discussion for requesting this medication. While this patient does present with cervical and lumbar radiculopathy, for which Gabapentin would be indicated, there is no documentation this medication has been helpful with the patient's neuropathic pain. MTUS page 60 require recording of pain and function with medications used for chronic pain. Furthermore, treating physician has not indicated quantity, nor duration of this medication. The request is not in accordance with guidelines. Therefore, Fanatrex is not medically necessary.

**Synapryn:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation National Library of Medicine's DailyMed Database ([dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?id=20039](http://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?id=20039)).

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

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines 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 4A's (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. Synapryn has been dispensed per treating physician reports dated 10/16/14 and 10/28/14. It is not known when this medication was initiated. Per progress report dated 10/28/14, treating physician states "Synapryn contains Tramadol and glucosamine, as well as other proprietary ingredients." It appears treating physician has quoted black box indications without providing a discussion for requesting this medication. In this case, treating physician has not stated how Synapryn reduces pain and significantly improves patient's activities of daily living. There are no pain scales or validated instruments addressing analgesia. There are no specific discussions regarding aberrant behavior, adverse reactions, ADL's, etc. No opioid pain agreement or CURES reports. No return to work, or change in work status, either. MTUS requires appropriate discussion of the 4A's. Furthermore, treating physician has not indicated quantity, nor duration of this medication. Given the lack of documentation as required by guidelines, the request is not medically necessary.

**Tabradol:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter.

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

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines 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. Cyclobenzaprine (Flexeril, Amrix, Fexmid, generic available): Recommended for a short course of therapy." Tabradol has been dispensed per treating physician reports dated 10/16/14 and 10/28/14. It is not known when this medication was initiated. Per progress report dated 10/28/14, treating physician states "Tabradol contains cyclobenzaprine, Methylsulfonylmethane (MSM) and other proprietary ingredient. In patients with musculoskeletal conditions, cyclobenzaprine has been consistently been found to be effective in most clinical trials compared to other drugs in its class." It appears treating physician has quoted black box indications without providing a discussion for requesting this medication. Guidelines do not suggest use of Cyclobenzaprine for chronic use longer than 2-3 weeks. Patient has been prescribed Tabradol (Cyclobenzaprine) at least from treating physician report dated 10/16/14, which is more than 1 months from the UR date of 11/26/14. Furthermore, treating physician has not indicated quantity, nor duration of this medication. The request is not in accordance with guidelines. Therefore, Tabradol is not medically necessary.

**Cyclobenzaprine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter.

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

**Decision rationale:** The Chronic Pain Medical Treatment Guidelines 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. Cyclobenzaprine (Flexeril, Amrix, Fexmid, generic available): Recommended for a short course of therapy." Cyclobenzaprine has been dispensed per treating physician reports dated 10/16/14 and 10/28/14. It is not known when this

medication was initiated. Per progress report dated 10/28/14, treating physician states " In patients with musculoskeletal conditions, cyclobenzaprine has been consistently been found to be effective in most clinical trials compared to other drugs in its class." It appears treating physician has quoted black box indications without providing a discussion for requesting this medication. However, guidelines do not suggest use of Cyclobenzaprine for chronic use longer than 2-3 weeks. The patient has been prescribed Tabradol (Cyclobenzaprine) at least from treating physician report dated 10/16/14, which is more than 1 months from the UR date of 11/26/14. Furthermore, treating physician has not indicated quantity, or duration of this medication. The request is not in accordance with guidelines. Therefore, Cyclobenzaprine is not medically necessary.

#### **EMG/NCV of the Bilateral Upper Extremities: Overturned**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 10 Elbow Disorders (Revised 2007) Page(s): 238 and table 10-6. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back Chapter.

**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: Nerve Conduction Studies and Electrodiagnostic Studies.

**Decision rationale:** For EMG/NCV, ACOEM guidelines page 262 states, appropriate electrodiagnostic studies may help differentiate between CTS and other conditions such as cervical radiculopathy. It may include nerve conduction studies or in more difficult cases, electromyography may be useful. NCS and EMG may confirm the diagnosis of CTS, but may be normal in early or mild cases of CTS. If the EDS are negative, tests may be repeated later in the course of treatment if symptoms persist. The treating physician has not provided reason for the request. There is no documentation that prior electrodiagnostic studies have been done. UR letter dated 11/26/14 states "there is no documentation of failure of conservative treatment." In this case, the patient has kept reporting constant pain and radiating symptoms in her upper extremities. Given that the patient has not had these tests performed in the past and the patients continuing radiating symptoms in her right arm, the request is medically necessary.

#### **EMG/NCV of the Bilateral Lower Extremities: 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 (ODG), Low Back Chapter.

**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: Nerve Conduction Studies and Electrodiagnostic Studies.

**Decision rationale:** For EMG, ACOEM guidelines page 303 support EMG and H-reflex tests to determine subtle, focal neurologic deficit. However, EMG is not recommended for clinically obvious radiculopathy per ODG guidelines. Regarding Nerve conduction studies, ODG

guidelines under Low Back chapter: Nerve conduction studies states, not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. ODG for Electrodiagnostic studies EDS- states, NCS, which are not recommended for low back conditions, and EMGs, which are recommended as an option for low back. The treating physician has not provided reason for the request. There is no documentation that prior electrodiagnostic studies have been done. UR letter dated 11/26/14 states "there is no documentation of failure of conservative treatment." In this case, the patient has kept reporting constant pain and radiating symptoms in her lower extremities. Given that the patient has not had these tests performed in the past and the patients continuing radiating symptoms in her lower extremities, the request is medically necessary.

**TENS Unit and Supplies (for home use): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114 and 116.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS in Chronic Intractable Pain Page(s): 114-116.

**Decision rationale:** According to MTUS Chronic Pain Management Guidelines the criteria for use of TENS in chronic intractable pain is "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." The treating physician has not provided reason for the request. There is no record that patient has trialed a TENS unit in the past, and a trial would be indicated. However, treating physician has not indicated what body part would be treated. MTUS requires documentation of one month prior to dispensing home units and there is no documentation of a trial. Furthermore, patient does not present with an indication for TENS unit. MTUS supports units for neuropathic pain, spasticity, MS, phantom pain and others. The request is not in accordance with guideline indications. Therefore, the request is not medically necessary.

**Hot/Cold Unit: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation PubMed - indexed for MEDLINE.

**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, Heat/Cold Applications.

**Decision rationale:** The ODG Guidelines, chapter 'Neck and Upper Back (Acute & Chronic)' and topic 'Heat/Cold Applications' states that hot/cold treatments are "Recommended. Insufficient testing exists to determine the effectiveness (if any) of heat/cold applications in treating mechanical neck disorders, though due to the relative ease and lack of adverse affects, local applications of cold packs may be applied during first few days of symptoms followed by applications of heat packs to suit patient." The treating physician has not provided reason for the

request, nor discussed what body part would be treated. The patient is suffering from chronic neck and back pain since injury date of 08/12/14. ODG guidelines recommend heat/cold applications only during the first few days of symptoms. Additionally, the progress reports do not specify the type of unit and extent of use. The provided progress reports lack relevant information required to make a determination. Therefore, the request is not medically necessary.

**Functional Capacity Evaluation: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 48. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Fitness for Duty Chapter.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 7 Independent Medical Examinations and Consultations, page 137-139.

**Decision rationale:** The MTUS does not discuss functional capacity evaluations. ACOEM chapter 7, page 137-139 states that the "examiner is responsible for determining whether the impairment results in functional limitations... The employer or claim administrator may request functional ability evaluations... may be ordered by the treating or evaluating physician, if the physician feels the information from such testing is crucial." ACOEM further states, "There is little scientific evidence confirming that FCE's predict an individual's actual capacity to perform in the workplace." In this case, the patient has undergone conservative treatment in the form of medications and hot and cold packs and chiropractic therapy, but continues to have pain. Provided progress reports do not mention a request from the employer or claims administrator. There is no discussion about the current request or prior evaluations in the reports. Routine FCE is not supported by the ACOEM. Therefore, the request is not medically necessary.

**Acupuncture to the Cervical/Thoracic/Lumbar Spine (three times weekly for six weeks): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** The Acupuncture Medical Treatment Guidelines states: "(i) Time to produce functional improvement: 3 to 6 treatments. (ii) Frequency: 1 to 3 times per week. (iii) Optimum duration: 1 to 2 months'. (D) Acupuncture treatments may be extended if functional improvement is documented as defined in Section 9792.20(e)." The treating physician has not provided reason for the request, nor a complete treatment history. Acupuncture note dated 10/20/14 shows patient has started treatment. MTUS requires documentation of functional improvement, defined by labor code 9792.20(e) as significant change in ADL's, or change in work status and reduced dependence on other medical treatments. In this case, treating physician has not documented functional improvement; there are no discussions regarding ADL's change in work status and reduction in medication use, for example. Furthermore, the request for 18

sessions exceeds what is allowed by guidelines. Therefore, the request is not medically necessary.

**Acupuncture to the Right and Left Shoulders (three times weekly for six weeks): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** The Acupuncture Medical Treatment Guidelines states: "(i) Time to produce functional improvement: 3 to 6 treatments. (ii) Frequency: 1 to 3 times per week. (iii) Optimum duration: 1 to 2 months'. (D) Acupuncture treatments may be extended if functional improvement is documented as defined in Section 9792.20(e)." The treating physician has not provided reason for the request, nor a complete treatment history. Acupuncture note dated 10/20/14 shows patient has started treatment. MTUS requires documentation of functional improvement, defined by labor code 9792.20(e) as significant change in ADL's, or change in work status and reduced dependence on other medical treatments. In this case, treating physician has not documented functional improvement; there are no discussions regarding ADL's change in work status and reduction in medication use, for example. Furthermore, the request for 18 sessions exceeds what is allowed by guidelines. Therefore, the request is not medically necessary.

**Acupuncture to the Right and Left Wrists (three times weekly for six weeks): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** The Acupuncture Medical Treatment Guidelines states: "(i) Time to produce functional improvement: 3 to 6 treatments. (ii) Frequency: 1 to 3 times per week. (iii) Optimum duration: 1 to 2 months. (D) Acupuncture treatments may be extended if functional improvement is documented as defined in Section 9792.20(e)." The treating physician has not provided reason for the request, nor a complete treatment history. Acupuncture note dated 10/20/14 shows patient has started treatment. MTUS requires documentation of functional improvement, defined by labor code 9792.20(e) as significant change in ADL's, or change in work status and reduced dependence on other medical treatments. In this case, treating physician has not documented functional improvement; there are no discussions regarding ADL's change in work status and reduction in medication use, for example. Furthermore, the request for 18 sessions exceeds what is allowed by guidelines. Therefore, the request is not medically necessary.