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| <b>Case Number:</b>   | CM15-0187608 |                              |            |
| <b>Date Assigned:</b> | 10/05/2015   | <b>Date of Injury:</b>       | 11/16/2014 |
| <b>Decision Date:</b> | 12/07/2015   | <b>UR Denial Date:</b>       | 08/24/2015 |
| <b>Priority:</b>      | Standard     | <b>Application Received:</b> | 09/23/2015 |

### 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, Pain Management

### 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 48 year old female, who sustained an industrial injury on November 16, 2014, incurring left shoulder injuries. She noted immediate shoulder pain radiating into her neck and lower back. She was diagnosed lumbar disc disease and disc bulging. Treatment included physical therapy and home exercise program, steroid injections, anti-inflammatory drugs, shock wave therapy, massage therapy, and activity restrictions. Currently, the injured worker complained of constant neck pain radiating down her left side, left arm, low back and lower extremities. She had persistent back pain rated 8-10 out of 10 on a pain scale from 1 to 10, numbness and tingling exacerbated with prolonged standing, walking, sitting and sleeping. The back pain radiated down into her both legs and into her feet. She reported difficulty gripping and grasping due to her left arm pain. She noted weakness, numbness and tingling in the left arm. The increased pain interfered with her activities of daily living, including household chores, gardening, and taking care of her children. The report dated July 6, 2015 identifies decreased sensation in the left L4, L5, and S1 dermatome. The note references a 4/15/2015 MRI identifying significant neuroforaminal narrowing at L3/4 with mild neuroforaminal narrowing at L5/S1. Authorization is requested for a pain management specialist to consider a lumbar epidural injection. A note dated June 1, 2015 indicates that the patient has undergone 2 MRIs of her low back and one MRI of the neck. The note indicates that the patient has previously received chiropractic treatment which "was beneficial." The treatment plan that was requested for authorization on September 23, 2015, included prescriptions for Sentra PM, Tramadol, Fexmid, Flurbiprofen-Lidocaine-Amitriptyline compound cream, Gabapentin-Cyclobenzaprine-Tramadol

compound cream; interferential unit, Electromyography and Nerve Conduction Velocity studies for the bilateral upper and lower extremities; Magnetic Resonance Imaging of the cervical spine and Chiropractic sessions therapy twice a week for four weeks. On August 24, 2015, a request for the listed medications, interferential unit, Electromyography and Nerve Conduction Velocity studies, Magnetic Resonance Imaging and chiropractic sessions were denied by utilization review.

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

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

#### **Sentra PM #60: 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 Chapter, Medical food and Sentra PM.

**Decision rationale:** Regarding the request for Sentra PM, California MTUS does not address the issue. ODG cites that Sentra PM is a proprietary blend of choline bitartrate, glutamate, and 5-hydroxytryptophan. Per ODG, "There is no known medical need for choline supplementation except for the case of long-term parenteral nutrition or for individuals with choline deficiency secondary to liver deficiency." Additionally, "Glutamic Acid" is used for treatment of hypochlohydria and achlorhydria. Treatment indications include those for impaired intestinal permeability, short bowel syndrome, cancer and critical illnesses. It is generally used for digestive disorders in complementary medicine. Within the documentation available for review, there is no indication of a condition for which the components of Sentra PM are supported. In the absence of such documentation, the currently requested Sentra PM is not medically necessary.

#### **Tramadol 50mg #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids (Classification), Opioids, California Controlled Substance Utilization Review and Evaluation System (CURES) [DWC], Opioids, criteria for use, Opioids for chronic pain, Opioids for neuropathic pain, Opioids for osteoarthritis, Opioids, cancer pain vs. nonmalignant pain, Opioids, dealing with misuse & addiction, Opioids, differentiation: dependence & addiction, Opioids, dosing, Opioids, indicators for addiction, Opioids, long-term assessment.

**Decision rationale:** Regarding the request for Ultram (tramadol), California Pain Medical Treatment Guidelines state that this is an opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional

improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no indication that the medication is improving the patient's function or pain (in terms of specific examples of functional improvement and percent reduction in pain or reduced NRS), no documentation regarding side effects, and no discussion regarding aberrant use. As such, there is no clear indication for ongoing use of the medication. Opioids should not be abruptly discontinued, but unfortunately, there is no provision to modify the current request to allow tapering. In light of the above issues, the currently requested Ultram (tramadol) is not medically necessary.

**Fexmid 7.5mg #90: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

**Decision rationale:** Regarding the request for cyclobenzaprine (Fexmid), Chronic Pain Medical Treatment Guidelines support the use of non-sedating muscle relaxants to be used with caution as a 2nd line option for the short-term treatment of acute exacerbations of pain. Guidelines go on to state that cyclobenzaprine specifically is recommended for a short course of therapy. Within the documentation available for review, there is no identification of a specific analgesic benefit or objective functional improvement as a result of the cyclobenzaprine. Additionally, it does not appear that this medication is being prescribed for the short-term treatment of an acute exacerbation, as recommended by guidelines. In the absence of such documentation, the currently requested cyclobenzaprine (Fexmid) is not medically necessary.

**Flurbiprofen 20% Lidocaine 5% Amitriptyline 5% 180gm cream: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** Regarding the request for Flurbiprofen 20% Lidocaine 5% Amitriptyline 5% 180gm cream, CA MTUS states that topical compound medications require guideline support for all components of the compound in order for the compound to be approved. Topical lidocaine is "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)." Additionally, it is supported only as a dermal patch. Guidelines do not support the use of topical antidepressants. As such, the currently requested Flurbiprofen 20% Lidocaine 5% Amitriptyline 5% 180gm cream is not medically necessary.

**Gabapentin 10% Cyclobenzaprine 6% Tramadol 10% 180gm cream: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** Regarding the request for Gabapentin 10% Cyclobenzaprine 6% Tramadol 10% 180gm cream, CA MTUS states that topical compound medications require guideline support for all components of the compound in order for the compound to be approved. Muscle relaxants drugs are not supported by the CA MTUS for topical use. Tramadol is not supported in topical form. Regarding topical gabapentin, Chronic Pain Medical Treatment Guidelines state that topical anti-epileptic medications are not recommended. They go on to state that there is no peer-reviewed literature to support their use. As such, the currently requested Gabapentin 10% Cyclobenzaprine 6% Tramadol 10% 180gm cream is not medically necessary.

**IF unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain Chapter.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Electrical stimulators (E-stim).

**Decision rationale:** Regarding the request for interferential unit, CA MTUS Chronic Pain Medical Treatment Guidelines state that interferential current stimulation is not recommended as an isolated intervention. They go on to state that patient selection criteria if interferential stimulation is to be used anyways include pain is ineffectively controlled due to diminished effectiveness of medication, side effects or history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercises, or unresponsive to conservative treatment. If those criteria are met, then in one month trial may be appropriate to study the effects and benefits. With identification of objective functional improvement, additional interferential unit use may be supported. Within the documentation available for review, there is no indication that the patient has met the selection criteria for interferential stimulation (pain is ineffectively controlled due to diminished effectiveness of medication, side effects or history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercises, or unresponsive to conservative treatment.). Additionally, there is no documentation that the patient has undergone an interferential unit trial with objective functional improvement and there is no provision for modification of the current request. In light of the above issues, the currently requested interferential unit is not medically necessary.

**EMG/NCV bilateral upper extremities:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Elbow Complaints 2007. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back Chapter.

**MAXIMUS guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck Chapter, Electrodiagnostic Studies, Electromyography, Nerve Conduction Studies.

**Decision rationale:** Regarding the request for EMG/NCV of bilateral upper extremities, Occupational Medicine Practice Guidelines state that the electromyography and nerve conduction velocities including H-reflex tests, may help identify subtle focal neurologic dysfunction in patients with neck or arm symptoms, or both, lasting more than three or four weeks. Within the documentation available for review, there are no recent physical examination findings identifying subtle focal neurologic deficits, for which the use of electrodiagnostic testing would be indicated. Additionally, it appears the patient has previously undergone a cervical MRI, and it is unclear whether this would be insufficient to explain the patient's neurologic findings if any are present. In the absence of such documentation, the currently requested EMG/NCV of bilateral upper extremities is not medically necessary.

**EMG/NCV bilateral lower extremities:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Electrodiagnostic Studies.

**Decision rationale:** Regarding the request for EMG/NCV of the lower extremities, Occupational Medicine Practice Guidelines state that unequivocal objective findings that identify specific nerve compromise on the neurologic exam are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery. When a neurologic examination is less clear however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. They go on to state that electromyography may be useful to identify subtle focal neurologic dysfunction in patients with low back symptoms lasting more than 3 to 4 weeks. ODG states that nerve conduction studies are not recommended for back conditions. They go on to state that there is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. Within the documentation available for review, there are findings consistent with left sided radiculopathy. However, MRI studies seem to explain the patient's findings. The patient has undergone 2 MRI studies of the lumbar spine previously. It is unclear whether the patient's symptoms and findings have changed since that time, or if the requesting physician feels that those findings are insufficient to explain the patient's current symptoms. Additionally, no neurologic findings have been identified in a dermatomal distribution affecting the patient's right lower extremity. There is no provision to modify the current request to a left-sided examination only. Due to the above issues, the currently requested EMG/NCV of the lower extremities is not medically necessary.

## **MRI of the cervical spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back Chapter.

**MAXIMUS guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck Chapter, MRI.

**Decision rationale:** Regarding the request for repeat cervical MRI, guidelines support the use of imaging for emergence of a red flag, physiologic evidence of tissue insult or neurologic deficit, failure to progress in a strengthening program intended to avoid surgery, and for clarification of the anatomy prior to an invasive procedure. Guidelines also recommend MRI after 3 months of conservative treatment. ODG states that repeat MRI is not routinely recommended in less there is a significant change in symptoms and or findings suggestive of significant pathology. Within the documentation available for review, there is no indication of any red flag diagnoses. Additionally there is no recent documentation of neurologic deficit in the upper extremities. Finally, there is no documentation of changed subjective complaints or objective findings since the time of the most recent cervical MRI. In the absence of such documentation the requested cervical MRI is not medically necessary.

## **Chiropractic therapy 2x4:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, and Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back Chapter.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

**Decision rationale:** Regarding the request for additional chiropractic care, Chronic Pain Medical Treatment Guidelines support the use of chiropractic care for the treatment of chronic pain caused by musculoskeletal conditions. Guidelines go on to recommend a trial of up to 6 visits over 2 weeks for the treatment of low back pain. With evidence of objective functional improvement, a total of up to 18 visits over 6 to 8 weeks may be supported. Within the documentation available for review, there is documentation of completion of prior chiropractic sessions, but there is no documentation of specific objective functional improvement with the previous sessions and remaining deficits that cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. Furthermore, it is unclear how many therapy sessions the patient has already undergone making it impossible to determine if the patient has exceeded the maximum number recommended by guidelines for their diagnosis. In the absence of clarity regarding the above issues, the currently requested chiropractic care is not medically necessary.