

<b>Case Number:</b>	CM15-0187692		
<b>Date Assigned:</b>	10/08/2015	<b>Date of Injury:</b>	03/31/2012
<b>Decision Date:</b>	12/14/2015	<b>UR Denial Date:</b>	09/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/24/2015

### 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 41 year old male, who sustained an industrial injury on 3-31-2012. A review of the medical records indicates that the injured worker is undergoing treatment for lumbar spine herniated nucleus pulposus (HNP). Bilateral wrist carpal tunnel syndrome, and muscle spasm. On 8-25-2015, the injured worker reported low back pain rated 4 out of 10 with radiating pain in the bilateral feet, and bilateral wrist pain unchanged since the 6-23-2015 visit. The Primary Treating Physician's report dated 8-25-2015, noted the lumbar spine tender with decreased range of motion (ROM) and spasm. The injured worker's current medications were not documented. Prior treatments have included physical therapy, chiropractic treatments, acupuncture, lumbar spine epidural steroid injection (ESI), Functional Capacity Evaluation (FCE), and splinting. The treatment plan was noted to include chiropractic treatments, urinalysis for toxicology, and lumbar spine shockwave. The injured worker's work status was instructed by the Physician to remain off work. The request for authorization dated 8-28-2015, requested a MRI of the lumbar spine, ortho shockwave for the lumbar spine, urinalysis test for toxicology, chiropractic 3 times a week for 4 weeks, Flexeril 7.5mg 1 tab by mouth twice a day #60, Flurbiprofen 10%/Capsaicin 0.025%/Menthol 2%/Camphor 1%, 120 gm, Ketoprofen 10%/Cyclobenzaprine 3%/Lidocaine 5%, 120 gm, Tramadol 50mg #30, Anaprox 550mg #60, Prilosec 40mg #60, and a follow-up visit with neurologist in 4 weeks. The Utilization Review (UR) dated 9-8-2015, denied the requests for a MRI of the lumbar spine, ortho shockwave for the lumbar spine, urinalysis test for toxicology, Flexeril 7.5mg 1 tab by mouth twice a day #60, Flurbiprofen 10%/Capsaicin 0.025%/Menthol 2%/Camphor 1%, 120 gm, Ketoprofen

10%/Cyclobenzaprine 3%/Lidocaine 5%, 120 gm, Prilosec 40mg #60, and a follow-up visit with neurologist in 4 weeks, and modified the requests for chiropractic 3 times a week for 4 weeks to certify chiropractic treatments 2 times a week x 2 weeks, Tramadol 50mg #30 to certify #20 only, and Anaprox 550mg #60 to certify #20 only.

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

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

**MRI Lumbar spine:** 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, MRI.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

**Decision rationale:** Regarding the request for repeat lumbar MRI, ACOEM Practice Guidelines do not have specific guidelines on when a repeat study is warranted. In general, lumbar MRI is recommended when there are unequivocal objective findings that identify specific nerve compromise on the neurologic examination in patients who do not respond to treatment and would consider surgery an option. The Official Disability Guidelines state that repeat MRIs should be reserved for cases in which a significant change in pathology has occurred. Within the documentation available for review, there is no identification of any objective findings that identify specific nerve compromise on the neurologic exam. Additionally, there is no documentation indicating how the patient's subjective complaints and objective findings have changed since the time of the most recent MRI of the lumbar spine. In the absence of clarity regarding those issues, the currently requested repeat lumbar MRI is not medically necessary.

**Ortho shockwave for lumbar spine:** 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, Shockwave therapy.

**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 Chapter, Shock wave therapy.

**Decision rationale:** Regarding the request for ESWT for the lumbar spine, the California MTUS does not address the issue. The Official Disability Guidelines specifically do not recommend shockwave therapy for the lumbar spine as the available evidence does not support its effectiveness in treating low back pain. The direct excerpt from the Official Disability Guidelines (ODG) Low Back Chapter, Shock wave therapy is as follows: "Not recommended. The available evidence does not support the effectiveness of ultrasound or shock wave for treating LBP. In the absence of such evidence, the clinical use of these forms of treatment is not justified and should be discouraged. (Seco, 2011)" Given this direct non-recommendation by guidelines, the currently requested ESWT for lumbar spine is not medically necessary.

**Urinalysis test for toxicology: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Drug testing.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Drug testing, Opioids, screening for risk of addiction (tests), Opioids, steps to avoid misuse/addiction.

**Decision rationale:** Regarding the request for a urine toxicology test, CA MTUS Chronic Pain Medical Treatment Guidelines state the drug testing is recommended as an option in patients on controlled substances. Guidelines go on to recommend monitoring for the occurrence of any potentially aberrant (or non-adherent) drug related behaviors. ODG recommends urine drug testing on a yearly basis for low risk patients, 2-3 times a year for moderate risk patients, and possibly once per month for high risk patients. There risk stratification is an important component in assessing the necessity and frequency of urine drug testing. With the documentation available for review, there is documentation of prescription of controlled substances. However, there is no notation of when the last previous urine toxicology testing was done. No risk factor assessment, such as the utilization of the Opioid Risk Tool or SOAPP is apparent in the records, which would dictate the schedule of random periodic drug testing. Given this, this request is not medically necessary.

**Chiropractic 3 times a week for 4 weeks: Upheld**

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

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

**Decision rationale:** In the case of this injured worker, the medical records indicate that previous chiropractic therapy has been trialed by this injured worker. However, the functional benefit of this previous chiropractic manipulation was not documented. Functional benefit can be defined as any clinically significant improvement in daily activities, reduction of work restrictions, or return to work. Given the absence of documented functional improvement, this request is not medically necessary.

**Flexeril 7.5mg 1 tab by mouth twice a day #60: Upheld**

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

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

**Decision rationale:** Regarding the request for cyclobenzaprine, 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. Given this, the current request is not medically necessary.

**Flurbiprofen 10%/Capsaicin 0.025%/Menthol 2%/Camphor 1%, 120 gm:** Upheld

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

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

**Decision rationale:** Regarding the request for compound cream containing topical flurbiprofen, CA MTUS states that topical compound medications require guideline support for all components of the compound in order for the compound to be approved. Guidelines state that topical NSAIDs are recommended for short-term use. Oral NSAIDs contain significantly more guideline support, provided there are no contraindications to the use of oral NSAIDs. Within the documentation available for review, there's no indication that the patient has obtained any specific objective functional improvement from the use of topical flurbiprofen. Additionally, there is no documentation that the patient would be unable to tolerate oral NSAIDs, which would be preferred, or that the topical flurbiprofen is for short term use, as recommended by guidelines. In the absence of clarity regarding those issues, the currently requested topical compound cream containing flurbiprofen is not medically necessary.

**Ketoprofen 10%/Cyclobenzaprine 3%/Lidocaine 5%, 120 gm:** Upheld

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

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

**Decision rationale:** Regarding the request for topical cyclobenzaprine, Chronic Pain Medical Treatment Guidelines state that topical muscle relaxants are not recommended. They go on to state that there is no evidence for the use of any muscle relaxants as a topical product. Therefore, in the absence of guideline support for topical muscle relaxants, be currently requested topical cream containing cyclobenzaprine is not medically necessary.

**Tramadol 50mg #30: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids (Classification).

**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, specific drug list.

**Decision rationale:** Regarding the request for Ultram (tramadol), Chronic Pain Medical Treatment Guidelines state that Ultram 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, 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.

**Anaprox 550mg #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

**Decision rationale:** Regarding the request for Anaprox, Chronic Pain Medical Treatment Guidelines state that NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Within the documentation available for review, there is no indication that Naproxen is providing any specific analgesic benefits (in terms of percent pain reduction, or reduction in numeric rating scale), or any objective functional improvement. Given this, the current request is not medically necessary.

**Prilosec 40mg #60: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

**Decision rationale:** Regarding the request for omeprazole (Prilosec), California MTUS states that proton pump inhibitors are appropriate for the treatment of dyspepsia secondary to NSAID therapy or for patients at risk for gastrointestinal events with NSAID use. Within the documentation available for review, there is no indication that the patient has complaints of dyspepsia secondary to NSAID use, a risk for gastrointestinal events with NSAID use, or another indication for this medication. In light of the above issues, the currently requested omeprazole (Prilosec) is not medically necessary.

**Follow-up visit with neurologist in 4 weeks:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

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

**Decision rationale:** Regarding the request for a office follow-up visit, California MTUS does not specifically address the issue. ODG cites that the need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible. Within the documentation available for review, there is no documentation of what is to be expected from further neurology follow up. There is no specific neurological complains on subjective or objective findings. Given this, this request is not medically necessary.