

<b>Case Number:</b>	CM14-0013597		
<b>Date Assigned:</b>	02/26/2014	<b>Date of Injury:</b>	07/11/2012
<b>Decision Date:</b>	06/25/2014	<b>UR Denial Date:</b>	01/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/03/2014

### 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 Pain Medicine, and is licensed to practice in Minnesota. 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 injured worker is a 50-year-old male who reported an injury on 07/11/2012. The mechanism of injury was not provided in the documentation. An electric diagnostic study performed on 12/05/2013 showed normal electromyography (EMG) studies as well as normal nerve conduction studies of the lower extremities. Per the progress note dated 01/27/2014, the injured worker reported pain to the mid and low back as well as bilateral legs and hips. On physical exam, he was noted to have decreased range of motion to the lumbar region with flexion at 30 degrees, right and left lateral bending were 15 degrees bilaterally and Lasegue's test was positive to the right. The injured worker was also noted to have tenderness over the lumbar spine. The diagnoses reported for the injured worker included thoracic sprain and strain, lumbar sprain and strain, Herniated Nucleus Pulposus (HNP) lumbar spine probable and rule out radiculopathy. The Request for Authorization for medical treatment specifically for the physical therapy was dated 02/14/2014. However, the provider's rationale for the physical therapy was not provided. The Request for Authorization for medical treatment and the provider's rationale for the remainder of the request for the MRI (magnetic resonance imaging) and x-ray of the lumbar spine, Prilosec, Fluriflex, transdermal analgesics, anti-inflammatory compound, and a transcutaneous electrical nerve stimulation (TENS) unit was not provided in the documentation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI OF THE LUMBAR SPINE:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305, 308-310.

**Decision rationale:** Per CA MTUS/ACOEM guidelines no tests are recommended for nonspecific low back pain. MRI (magnetic resonance imaging) is recommended when cauda equina, tumor, infection, or fractures are strongly suspected and plain film radiographs are negative. MRI is the test of choice for patients with prior back surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause. There was a lack of documentation regarding neurological deficits, the injured worker was noted to have tenderness and some decreased range of motion; however, there was a lack of documentation noting neurological deficits. The documentation reported the injured worker underwent both an electromyography (EMG) and a NCV (nerve conduction velocity) which were normal. Therefore, the request for the MRI of the lumbar spine is non-certified.

**X-RAYS OF 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).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

**Decision rationale:** Per CA MTUS/ACOEM guidelines, lumbar spine x rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least six weeks. However, it may be appropriate when the physician believes it would aid in patient management. There was a lack of objective clinical documentation regarding the lumbar spine. The documentation submitted did not indicate the injured worker had findings that would support the indication for x-rays of the lumbar spine. There was documentation of tenderness to palpation of the musculature of the spine. In addition, the injured worker was reported to have had x-rays at the time of the injury and again on 02/01/2013; however, there was a lack of documentation regarding any change in the findings. The documentation reported the injured worker underwent both an electromyography (EMG) and a NCV (nerve conduction velocity) which were normal. Therefore, the request for x-rays of the lumbar spine is non-certified.

**PRILOSEC 20 MG:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 69.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms and Cardiovascular Risk Page(s): 68. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, proton pump inhibitors.

**Decision rationale:** The CA MTUS Guidelines state the injured worker's risk for gastrointestinal events should be evaluated and determined if the injured worker is greater than 65 years; has a history of peptic ulcer, gastrointestinal bleeding or perforation; or concurrent use of acetylsalicylic acid (ASA), corticosteroids, and/or anticoagulant; or high dose/multiple non-steroidal anti-inflammatory drugs (NSAIDs). Recent studies tend to show that H. Pylori does not act synergistically with NSAIDs to develop gastroduodenal lesions. The Official Disability Guidelines (ODG) recommended proton pump inhibitors (PPI) for patients at risk for gastrointestinal events. In general; however, the use of a PPI should be limited to the recognized indications and used at the lowest dose for the shortest possible amount of time. The documentation submitted did not indicate the injured worker had findings that would support he was at risk for gastrointestinal events. There was a lack of clinical documentation regarding the injured workers use of medications that may cause gastrointestinal distress. In addition, there was a lack of frequency in the request as submitted. Therefore, the request for Prilosec 20mg is non-certified.

**FLURIFLEX COMPOUND (UNSPECIFIED DOSAGE/QUANTITY):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS Page(s): 111-113.

**Decision rationale:** Per CA MTUS guidelines, topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The MTUS states that any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The efficacy of non-steroidal anti-inflammatory drugs (NSAIDs) in clinical trials for topical treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first two weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another two-week period. There is no evidence for use of any other muscle relaxant, such as cyclobenzaprine, for topical application. The addition of cyclobenzaprine to other agents is not recommended. Fluriflex is a compounded drug containing Flurbiprofen and cyclobenzaprine. In this case, the documentation submitted did not indicate the injured worker had findings that would support the diagnoses of neuropathic pain. There was a lack of clinical documentation regarding other medications that had been utilized in the past and the efficacy of those medications. In addition, there was a lack of documentation regarding the dosage and quantity of the requested medication. Therefore, the request for Fluriflex compound is non-certified.

**TRANSDERMAL ANALGESICS (UNSPECIFIED NAME/DOSAGE/QUANTITY):**

Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS, Page(s): 111.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TOPICAL ANALGESICS, FENTANYL TRANSDERMAL Page(s): 93, 111.

**Decision rationale:** Per CA MTUS guidelines, topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. These agents are applied locally to painful areas with advantages that include lack of systemic side effects, absence of drug interactions, and no need to titrate. In this case, the documentation submitted did not indicate the injured worker had findings that would support the use of transdermal analgesics. There was a lack of clinical documentation regarding other medications utilized and the efficacy of those medications. In addition, there was a lack of documentation regarding the specific name, dosage, and quantity of the medication. Therefore, the request for Transdermal analgesics is non-certified.

**ANTI-INFLAMMATORY COMPOUND (UNSPECIFIED NAME/DOSAGE/ QUANTITY):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-112.

**Decision rationale:** Per CA MTUS guidelines, topical analgesics are largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical non-steroidal anti-inflammatory drugs (NSAIDs) have been shown in meta-analysis to be superior to placebo during the first two weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another two-week period. These medications may be useful for chronic musculoskeletal pain, but there are no long-term studies of their effectiveness or safety. The documentation submitted did not indicate the injured worker had findings that would indicate the use of anti-inflammatory compounds. There was a lack of clinical documentation regarding other medications utilized and the efficacy of those medications. In addition, there was a lack of documentation regarding the specific name, dosage, and quantity of the medication. Therefore, the request for Anti-inflammatory compound is non-certified.

**PHYSICAL THERAPY:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL MEDICINE, Page(s): 99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL MEDICINE Page(s): 98-99.

**Decision rationale:** Per CA MTUS guidelines, physical medicine is recommended as indicated. Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. The guidelines recommend allowing for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. The recommended visits for myalgia and myositis, unspecified were 9-10 visits over 8 weeks and the recommended visits for neuralgia, neuritis, and radiculitis, unspecified were 8-10 visits over 4 weeks. There was a lack of clinical documentation regarding treatments utilized in the past as well as the efficacy of those treatments. The documentation submitted did not indicate the injured worker had findings that would support the need for physical therapy. In addition, the request does not identify the reason for nor length of the physical therapy requested. Therefore, the request for physical therapy is non-certified.

**TENS UNIT (UNSPECIFIED PURCHASE OR RENTAL/DURATION):** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TRANSCUTANEOUS ELECTROTHERAPY Page(s): 114-117.

**Decision rationale:** Per the CA MTUS guidelines specific criteria is required for the use of a transcutaneous electrical nerve stimulation (TENS) unit. There must be evidence that other appropriate pain modalities have been tried (including medication) and failed, other ongoing pain treatment should also be documented during the trial period. The TENS unit is appropriate for neuropathic pain. TENS may be a supplement to medical treatment in the management of spasticity in spinal cord injury. The MTUS guidelines recommend a one-month trial period of the TENS unit should be documented with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; rental would be preferred over purchase during this trial. A treatment plan including the specific short- and long-term goals of treatment with the TENS unit should be submitted. There was a lack of clinical documentation regarding other appropriate pain modalities that had been utilized and the efficacy of the modalities. The documentation submitted did not indicate the injured worker had findings that would support the rationale for the use of the TENS unit. There was a lack of documentation regarding a previous trial of the TENS unit and the outcome of that trial. In addition the request did not identify the duration of use or if this was for rental or purchase. Therefore, the request for a TENS unit is non-certified.