

<b>Case Number:</b>	CM14-0184816		
<b>Date Assigned:</b>	11/12/2014	<b>Date of Injury:</b>	12/26/2013
<b>Decision Date:</b>	12/19/2014	<b>UR Denial Date:</b>	10/29/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/06/2014

### 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 Family Medicine 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:

This is a 31-year-old male patient who reported an industrial injury on 12/26/2013, one (1) year ago, attributed to the performance of his usual and customary job tasks reported as loading a an appliance into a truck on a dolly when the load shifted falling toward him. The patient complained of neck pain, low back pain, and right shoulder pain. The eight (8) objective findings on examination included tenderness to the thoracic paraspinals was cervical muscle guarding; tenderness to palpation of the diminished range of motion of the cervical spine and lumbar spine; right shoulder with normal range of motion; no atrophy; negative orthopedic testing; motor strength is 5/5. The patient was diagnosed with cervical spine sprain/strain; thoracic spine sprain/strain; and lumbar spine sprain/strain. The patient was treated with chiropractic care in physical therapy along with Toradol injections and a TENS unit. The patient was prescribed gabapentin 100 mg #90; cyclobenzaprine 7.5 mg #60; naproxen 550 mg #60; Methoderm gel 120 Graham; Norco 10/325 mg #60; and MRI study of the cervical spine; and an EMG/NCV of the bilateral upper extremities.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 prescription of Gabapentin 100mg #90: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines anti-epilepsy drugs; specific anti-epilepsy drugs gabapentin Page(s): 16; 18. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) chronic pain chapter 8/8/2008 page 110 Official Disability Guidelines (ODG) pain chapter-medications for chronic pain

**Decision rationale:** The treating physician has prescribed gabapentin 100 mg tid #90 to the patient for the treatment of chronic back/neck pain over a prolonged period of time; however, there is no documented neuropathic pain. There is no documentation of functional improvement with the prescription of the gabapentin 100 mg t.i.d. There is no documented objective evidence of a nerve impingement radiculopathy. The patient is noted to the lumbar spine. The patient is not demonstrated to have neuropathic pain for which Gabapentin is recommended by evidence-based guidelines. The patient is not documented on examination to have neuropathic pain. The prescription of Gabapentin (Neurontin) was not demonstrated to have been effective for the patient for the chronic pain issues. The treating physician has provided this medication for the daily management of this patient's chronic pain. Gabapentin or pregabalin is not recommended for treatment of chronic, non-neuropathic pain by the American College of Occupational and Environmental Medicine (ACOEM) Guidelines. The ACOEM Guidelines revised chronic pain chapter states there is insufficient evidence for the use of Gabapentin or Lyrica for the treatment of axial lower back pain; chronic lower back or neck pain; or chronic lower back pain with radiculopathy. The California Medical Treatment Utilization Schedule (MTUS) and the Official Disability Guidelines state there is insufficient evidence to support the use of Gabapentin or Lyrica for the treatment of chronic axial lower back pain. The prescription of Gabapentin for neuropathic pain was not supported with objective findings on physical examination. There was objective evidence that the recommended conservative treatment with the recommended medications have been provided prior to the prescription of gabapentin for chronic pain. Presently, there is no documented objective evidence of neuropathic pain for which the use of Gabapentin is recommended. The prescription of Gabapentin is recommended for neuropathic pain and is used to treat postherpetic neuralgia and painful polyneuropathy, such as, diabetic polyneuropathy. Anti-epilepsy drugs (AEDs) are recommended on a trial basis (Lyrica/gabapentin/pregabalin) as a first-line therapy for painful polyneuropathy, such as, diabetic polyneuropathy. The updated chapter of the ACOEM Guidelines does not recommend the use of Lyrica or Gabapentin (Neurontin) for the treatment of axial back pain or back pain without radiculopathy. The use of Gabapentin is for neuropathic pain; however, evidence based guidelines do not recommend the prescription of Gabapentin for chronic lower back pain with a subjective or objective radiculopathy and favors alternative treatment. The request for gabapentin 100 mg t.i.d. #90 is not demonstrated to be medically necessary.

**1 prescription of Cyclobenzaprine 7.5mg #60: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47, Chronic Pain Treatment Guidelines Muscle relaxants for pain Page(s): 63-

64. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter-medications for chronic pain; muscle relaxants; cyclobenzaprine

**Decision rationale:** The prescription for Flexeril (cyclobenzaprine) 7.5 mg #60 is recommended for the short-term treatment of muscle spasms and not for the long-term treatment of chronic pain. The patient has been prescribed muscle relaxers on a long-term basis contrary to the recommendations of the California Medical Treatment Utilization Schedule (MTUS). The patient is prescribed muscle relaxers on a routine basis for chronic pain. The muscle relaxers are directed to the relief of muscle spasms. The chronic use of muscle relaxants is not recommended by the California MTUS, the American College of Occupational and Environmental Medicine (ACOEM) Guidelines, or the Official Disability Guidelines (ODG) for the treatment of chronic pain. The use of muscle relaxants are recommended to be prescribed only briefly in a short course of therapy. There is no medical necessity demonstrated for the use of muscle relaxants for more than the initial short-term treatment of muscle spasms. There is a demonstrated medical necessity for the prescription of muscle relaxers on a routine basis for chronic back pain. The cyclobenzaprine was used as an adjunct treatment for muscle and there is demonstrated medical necessity for the Cyclobenzaprine/Flexeril for the cited industrial injury. The continued prescription of a muscle relaxant was not consistent with the evidence-based guidelines. The California MTUS states that cyclobenzaprine is recommended for a short course of therapy. Limited, mixed evidence does not allow for a recommendation for chronic use. Cyclobenzaprine is a skeletal muscle relaxant and a central nervous system depressant with similar effects to tricyclic antidepressants. Evidence-based guidelines state that this medication is not recommended to be used for longer than 2 to 3 weeks. There is no demonstrated medical necessity for the prescription of cyclobenzaprine 7.5 mg #60 for the effects of the industrial injury.

**1 prescription of Naproxen Sodium 550mg #60: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines anti-inflammatory medications Page(s): 67-68. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter-medications for chronic pain and NSAIDs

**Decision rationale:** The use of Anaprox/Naproxen unspecified dose and quantity is consistent with the currently accepted guidelines and the general practice of medicine for musculoskeletal strains and injuries; however, there is no evidence of functional improvement or benefit from this NSAID. There is no rationale to support the medical necessity. There is no evidence that OTC NSAIDs would not be appropriate for similar use for this patient. The prescription of Naproxen is not supported with appropriate objective evidence as opposed to the NSAIDs available OTC. The prescription of Naproxen should be discontinued in favor of OTC NSAIDs. There is no provided evidence that the available OTC NSAIDs were ineffective for the treatment of inflammation. The prescription for naproxen 550 mg #60 is not demonstrated to be medically necessary.

## **1 prescription of Menthoderm gel 120gm: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47, Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter-topical analgesics, topical analgesics compounded

**Decision rationale:** The prescription for Menthoderm topical gel 120 grams is not medically necessary for the treatment of the patient for pain relief for the orthopedic diagnoses of the patient. There is no Orthopedic clinical documentation submitted with the billing to demonstrate the use of the topical creams for appropriate diagnoses or for the recommended limited periods of time. It is not clear that the topical medications are medically necessary in addition to prescribed oral medications. There is no provided subjective/objective evidence that the patient has failed or not responded to other conventional and recommended forms of treatment for relief of the effects of the industrial injury. Only if the subjective/objective findings are consistent with the recommendations of the ODG, then topical use of topical preparations is only recommended for short-term use for specific orthopedic diagnoses. The use of topical NSAIDs is documented to have efficacy for only 2-4 weeks subsequent to injury and thereafter is not demonstrated to be as effective as oral NSAIDs. There is less ability to control serum levels and dosing with the topicals. The patient is not demonstrated to have any GI issue at all with NSAIDs. The request for Menthoderm topical gel 120 grams is not medically necessary for the treatment of the patient for the diagnosis of reported chronic neck and low back pain. The use of the topical creams/gels does not provide the appropriate therapeutic serum levels of medications due to the inaccurate dosing performed by rubbing variable amounts of creams on areas that are not precise. The volume applied and the times per day that the creams are applied are variable and do not provide consistent serum levels consistent with effective treatment. There is no medical necessity for the addition of creams to the oral medications in the same drug classes. There is no demonstrated evidence that the topicals are more effective than generic oral medications. The prescription is accompanied with a state of medical necessity by the vendor, which states, "compounded medications are not absorbed by the stomach so they do not cause any of the dangerous die effects that may be experienced by taking medications orally (ie damage to the liver and kidneys)." In fact, medications that are transdermal or oral enter the blood stream and are ultimately broken down in the liver or kidneys. The breakdown of the prescribed topical medication still occurs in the kidneys and liver. "Compounded medications are absorbed through the skin so less medication enters the blood stream. The benefit of this is that there is reduced chance of building tolerance to drugs thereby curbing any potential addiction to medication." There is no objective evidence to support this contention and high serum levels can be achieved through transdermal applications. The serum levels can be similar and have the same propensity towards tolerance. "Compounds have fewer possibilities of drug interactions because less of the medication enters the blood stream" is not supported with objective evidence. The ability to interact with other medications in the blood stream is the same whether the route of absorption is oral or transdermal. "Compounds provide faster relief than medications taken orally. With compound medications you get fast pain relief to the affected area within a matter of minutes of

application" is also not supported with objective evidence. The use of Menthoderml topical gel 120 grams not supported by the applicable ODG guidelines as cited below. The continued use of topical NSAIDs for the current clinical conditions is not otherwise warranted or demonstrated to be appropriate. There is no documented objective evidence that the patient requires both the oral medications and the topical compounded medication for the treatment of the industrial injury. The prescription for Menthoderml topical gel 120 grams is not medically necessary for the treatment of the patient's neck and low back pain complaints. The prescription of Menthoderml topical gel 120 grams is not recommended by the CA MTUS and the Official Disability Guidelines. The continued use of topical NSAIDs for the current clinical conditions is not otherwise warranted or appropriate - noting the specific comment, "There is little evidence to utilize topical NSAIDs for treatment of osteoarthritis of the spine, hip, or shoulder." The objective findings in the clinical documentation provided do not support the continued prescription of for the treatment of chronic low back pain. There is no demonstrated medical necessity for the prescription of the topical Menthoderml gel 120 grams for the treatment of chronic neck and low back pain.

### **1 cervical MRI study: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines- Neck (Acute & Chronic)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 182, 177-178. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) neck and upper back chapter-MRI

**Decision rationale:** The request for a magnetic resonance imaging (MRI) of the cervical spine was not supported with objective findings on examination to support medical necessity. The patient is 12 months s/p DOI and has no documented neurological or radiculopathy deficits on examination. There was no objective evidence to support the medical necessity of the requested cervical spine MRI. The patient was not documented to have been provided complete conservative treatment. The criteria recommended by evidence-based guidelines were not documented to support the medical necessity of the requests. There is no rationale provided by the requesting provider to support the medical necessity of a MRI of the cervical spine as a screening study. There are no documented progressing neurological deficits. There are no demonstrated red flag diagnoses as recommended by the American College of Occupational and Environmental Medicine (ACOEM) Guidelines in order to establish the criteria recommended for a MRI of the cervical spine. The medical necessity of the requested MRI of the cervical spine was not supported with the subjective/objective findings recommend by the ACOEM Guidelines or the Official Disability Guidelines for the authorization of a cervical spine MRI. The patient's treatment plan did not demonstrate an impending surgical intervention or any red flag diagnoses. The treatment plan was not demonstrated to be influenced by the obtaining of the Cervical MRI. There were no demonstrated sensory or motor neurological deficits on physical examination; there were no demonstrated changes to the patient's neurological examination other than the subjective pain complaint; and the patient was not shown to have failed a conservative program of strengthening and conditioning. The patient is not documented as contemplating surgical

intervention to the cervical spine. There were no documented clinical changes in the patient's clinical status or documented motor/sensory neurological deficits that would warrant the authorization of a MRI of the cervical spine/thoracic spine or meet the recommendations of the currently accepted evidence-based guidelines. There is no provided rationale for the MRI of the cervical spine/thoracic spine by the requesting provider. The MRI results were not noted to affect the course of the recommended conservative treatment. The functional assessment for the provided conservative therapy since the date of injury has not been documented or provided in the physical therapy documentation. There was no demonstrated medical necessity for a MRI of the cervical spine.

### **1 EMG/NCV of the upper 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 Neck and Upper Back (Acute & Chronic)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment, Chapter 8 Neck and Upper Back Complaints, Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 12 Low Back Complaints Page(s): 48; 178; 261; 298, 301, 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) neck and upper back-electromyography: carpal tunnel syndrome-EDS

**Decision rationale:** The request for the authorization of the repeated Electromyogram (EMG) and Nerve Conduction (NCV) Velocity studies of the bilateral upper extremities (BUE) is not supported with sufficient objective clinical findings that would contribute to the future treatment plan of the patient and is not supported by any changes in objective findings documented on examination. There are no documented progressive neurological deficits to support the medical necessity of Electrodiagnostic studies. The evaluation to rule out a peripheral nerve entrapment or cervical radiculopathy is not supported with the documented objective findings documented on examination. There is no demonstrated medical necessity for the requested Electrodiagnostic studies without the failure of conservative treatment. There are no objective or subjective findings documented that require immediate Electrodiagnostic studies as no surgical intervention is contemplated and the patient has not failed injections and HEP. The Electrodiagnostic studies were ordered due to reported subjective complaints without objective findings on examination. There are only symptoms with objective findings documented for the left upper extremity and no symptoms documented for the right upper extremity. There are no documented changes in the neurological status of the patient that would require Electrodiagnostic studies. The clinical narrative documented that the Electrodiagnostic studies were ordered as screening studies. There is no demonstrated medical necessity for the requested BUE EMG/NCS screening examination. The provider has documented no objective findings on examination to be further evaluated with Electrodiagnostic studies prior to the provision of conservative treatment. There is no documented change in clinical status or progressive radiculopathy or neuropathy. There is no rationale supported with objective evidence to support the medical necessity of a repeated Electrodiagnostic study to the bilateral upper extremities. There are subjective findings; however, there are no significant neurological deficits documented that require Electrodiagnostic studies. The Electrodiagnostic test is ordered as a screening test. There is no contemplated

surgical intervention for a cervical radiculopathy or peripheral nerve entrapment neuropathy. There is no demonstrated impending surgical intervention being contemplated and the patient has not completed ongoing conservative care. There is no objective evidence that the patient has median or ulnar entrapment neuropathy that would qualify for surgical intervention. The EMG/NCS is for diagnostic purposes for cervical radiculopathy or peripheral nerve compression neuropathy, which are not documented by objective findings. There is no medical necessity for the requested repeated Electrodiagnostic studies for the evaluation of the patient at this time prior to the provision of conservative treatment. The current clinical objective findings did not demonstrate a significant change in the clinical status of the patient as to nerve entrapment neuropathies and there was not rationale for the requested Electrodiagnostic study other than to "rule out" a nerve compression neuropathy or a nerve root impingement neuropathy with a screening study. There were no documented clinical changes or objective findings to support the medical necessity of a BUE EMG/NCS study. The EMG/NCS would only be necessary to evaluate for the medical necessity of surgical intervention for moderate to severe symptoms with objective findings documented on examination. The criteria recommended by the CA MTUS, the ACOEM Guidelines, or the Official Disability Guidelines for the use of Electrodiagnostic studies for the BUEs were not documented by the requesting provider. There was no demonstrated objective evidence, such as, a neurological deficit or change in status that supports the authorization of EMG/NCS studies. There is no demonstrated medical necessity for a repeated Electrodiagnostic studies directed to bilateral upper extremity radiculopathies or peripheral neuropathies based on the objective findings documented.