

<b>Case Number:</b>	CM14-0092503		
<b>Date Assigned:</b>	08/08/2014	<b>Date of Injury:</b>	04/23/2007
<b>Decision Date:</b>	09/22/2014	<b>UR Denial Date:</b>	05/27/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/18/2014

### 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 Occupational 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:

The patient is a 49-year-old male who has submitted a claim for lumbar radiculopathy and myofascial pain syndrome associated with an industrial injury date of 4/23/2007. Medical records from 2013 to 2014 were reviewed. Patient complained of low back pain radiating to bilateral lower extremities, associated with weakness, numbness and tingling sensation. Patient likewise complained of reflux symptoms. Physical examination of the lumbar spine showed restricted range of motion, tenderness, muscle spasm, and trigger points. Sensation was diminished at L4, L5, and S1 dermatomes, bilaterally. Reflexes were normal. Motor strength was decreased at bilateral L5 and S1 myotomes. Straight leg raise test was positive bilaterally at 40 degrees. MRI of the lumbar spine, dated 7/8/2007, demonstrated moderate central disk protrusion at L4 to L5 with mild degree of circumferential spinal stenosis. Appeal letter, dated 5/31/2014, stated that omeprazole is for prophylactic treatment of gastric ulcers and tizanidine is for acute treatment of muscle spasms. Acupuncture was likewise beneficial in the past as stated. Treatment to date has included lumbar epidural steroid injection, sacroiliac joint injection, physical therapy, acupuncture, trigger point injections, and medications such as Gabapentin, Omeprazole, Neurontin, Terocin patch, and topical creams (since 2013). Utilization review from 5/27/2014 denied the request for Neurontin 600mg QTY: 100 Refills:5 because of no documented efficacy; denied Zanaflex 4mg QTY: 270 Refills:2 because long-term use was not recommended; denied Omeprazole 20mg QTY: 100 Refills 1 because of no documented gastrointestinal complaint; denied Terocin patch QTY: 10 Refills 3 because there was no documentation of failed trials of first line recommendations; denied Right L4 and L5 Epidural steroid injection because of lack of positive neurological findings consistent with objective radiculopathy; and denied Acupuncture to the Lumbar spine 2x4 QTY: 8 because of no documented functional gains from previous sessions.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Neurontin 600mg QTY: 100 Refills:5:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs (AEDs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Anti-Epilepsy Drugs Page(s): 16-17.

**Decision rationale:** As stated on pages 16 - 17 of CA MTUS Chronic Pain Medical Treatment Guidelines, antidepressants, such as Pregabalin and Gabapentin, are recommended as a first line option for neuropathic pain, i.e., painful polyneuropathy. In this case, the patient has been on Neurontin as early as 2013. Patient's manifestation of chronic low back pain radiating to bilateral lower extremities associated with numbness, is consistent with neuropathic pain. However, there was no documentation concerning pain relief and functional improvement derived from its use. Moreover, there was no discussion as to why 5 refills should be certified at this time. Therefore, the request for Neurontin 600mg QTY: 100 Refills: 5 is not medically necessary.

**Zanaflex 4mg QTY: 270 Refills2:** Upheld

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

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

**Decision rationale:** According to page 63 of the CA MTUS Chronic Pain Medical Treatment Guidelines, non-sedating muscle relaxants are recommended with caution as a second-line option for short-term treatment of acute exacerbations in patients with chronic low back pain. In this case, the patient has been on Zanaflex since 2013. The most recent physical examination still showed evidence of muscle spasm, however long-term use of muscle relaxant is not recommended. Moreover, there was no discussion as to why Qty 270 and 2 refills should be certified at this time. Therefore, the request for Zanaflex 4mg QTY: 270 Refills: 2 is not medically necessary.

**Omeprazole 20mg QTY: 100 Refills 1:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment for Worker's Compensation, Pain Procedure Summary, Proton Pump Inhibitors (PPI's).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI Symptoms, and Cardiovascular Risk Page(s): 68.

**Decision rationale:** As stated on page 68 of CA MTUS Chronic Pain Medical Treatment Guidelines, clinicians should weigh the indications for NSAIDs against both GI and cardiovascular risk factors: age > 65 years, history of peptic ulcer, GI bleeding or perforation; concurrent use of ASA, corticosteroids, or anticoagulant; or on high-dose/multiple NSAIDs. Patients with intermediate risk factors should be prescribed proton pump inhibitors (PPI). In this case, patient has been on Omeprazole since 2013. Patient reported reflux symptoms secondary to intake of multiple oral medications. The medical necessity for a proton pump inhibitor has been established. Therefore, the request for Omeprazole 20mg QTY: 100 Refills 1 is medically necessary.

**Terocin patches QTY: 10 Refills 3:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines LidocainePpatch Page(s): 56-57. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Section, Topical Salicylate.

**Decision rationale:** Terocin patches contain both Lidocaine and Menthol. Pages 56 to 57 of CA MTUS Chronic Pain Medical Treatment Guidelines state that topical Lidocaine may be 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). Regarding the Menthol component, CA MTUS does not cite specific provisions, but the ODG Pain Chapter states that the FDA has issued an alert in 2012 indicating that topical OTC pain relievers that contain Menthol, Methyl Salicylate, or Capsaicin, may in rare instances cause serious burns. In this case, records reviewed showed that patient was on Terocin patch since 2013. Patient was initially on Gabapentin; however, neuropathic pain symptoms persisted hence the adjuvant therapy of lidocaine patch. The medical necessity has been established. Therefore, the request for Terocin Patches QTY: 10 Refills: 3 is medically necessary.

**Right L4 and L5 Epidural Steroid Injection:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroidal Injections (ESIs) Page(s): 46.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection Page(s): 46.

**Decision rationale:** As stated on page 46 of CA MTUS Chronic Pain Medical Treatment Guidelines, epidural steroid injection (ESI) is indicated among patients with radicular pain that has been unresponsive to initial conservative treatment. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing.

Repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks. In this case, patient complained of low back pain radiating to bilateral lower extremities, associated with weakness, numbness and tingling sensation. Physical examination showed weak bilateral L5 and S1 myotomes, diminished sensation at L4, L5, and S1 dermatomes bilaterally, and positive straight leg raise test bilaterally. MRI of the lumbar spine, dated 7/8/2007, demonstrated moderate central disk protrusion at L4 to L5 with mild degree of circumferential spinal stenosis. Clinical manifestations were consistent with radiculopathy; however, there was no evidence of nerve root impingement on MRI. Moreover, utilization review stated that patient underwent epidural steroid injection previously. However, there was no documentation concerning percentage and duration of pain relief to warrant a second ESI. Guideline criteria were not met. Therefore, the request for Right L4 and L5 Epidural Steroid Injection is not medically necessary.

**Acupuncture to the Lumbar spine 2times a week for 4 weeks QTY: 8: Upheld**

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

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

**Decision rationale:** CA MTUS Acupuncture Medical Treatment Guidelines state that acupuncture is used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Acupuncture treatments may be extended if functional improvement is documented. The frequency and duration to produce functional improvement is 3 - 6 treatments, frequency of 1 - 3 times per week, and duration of 1 - 2 months. It may be extended if functional improvement is documented. In this case, patient has received acupuncture treatment in the past; however, the exact number of visits is not documented in the medical records submitted. There was no documentation stating the pain reduction, functional improvement or decreased medication-usage associated with the use of acupuncture. The medical necessity cannot be established due to insufficient information. Therefore, the request for Acupuncture to the Lumbar Spine 2times a week for 4 weeks QTY: 8 are not medically necessary.