

<b>Case Number:</b>	CM15-0112927		
<b>Date Assigned:</b>	06/23/2015	<b>Date of Injury:</b>	01/21/2015
<b>Decision Date:</b>	10/02/2015	<b>UR Denial Date:</b>	06/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/11/2015

### 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: Preventive Medicine, Occupational Medicine

### 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 30 year old male, who sustained an industrial injury on 1/21/2015. Diagnoses include rule out lumbar disc protrusion and rule out lumbar radiculitis versus radiculopathy. Treatment to date has included diagnostics, physical therapy and medications. Per the Primary Treating Physician's Progress Report dated 5/12/2015, the injured worker reported right leg numbness and lower back cramping pain that spreads to the buttocks. Physical examination revealed no bruising, swelling, atrophy or lesion present in the lumbar spine. Ranges of motion were decreased in all planes. The plan of care included, and authorization was requested, for topical medications Capsaicin/Flurbiprofen/Gabapentin/menthol/camphor and Gabapentin/Amitriptyline/ dextromethorphan, cold/heat therapy unit, TENS/EMS unit, RTW/FCE testing, magnetic resonance imaging (MRI) lumbar spine, vSNCT lumbar spine, x-rays lumbar spine, 12 sessions of acupuncture and 12 sessions of chiropractic.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Capsaicin 0.025%, Flurbiprofen 15%, Gabapentin 10%, Menthol 2%, Camphor 2%:**

Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 105.

**Decision rationale:** Capsaicin topical is recommended only as an option in patients who have not responded or are intolerant to other treatments. The medical record contains no documentation that the patient is intolerant of unresponsive to other treatments. According to the MTUS, there is little to no research to support the use of many of these compounded topical analgesics. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Capsaicin 0.025%, Flurbiprofen 15%, Gabapentin 10%, Menthol 2%, Camphor 2% is not medically necessary.

**Gabapentin 15%, Amitriptyline 4%, Dextromethorphan 10%, 180gm:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 111-113.

**Decision rationale:** According to the MTUS, there is little to no research to support the use of many of these compounded topical analgesics. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Gabapentin is not recommended. There is no peer-reviewed literature to support use. Gabapentin 15%, Amitriptyline 4%, Dextromethorphan 10%, 180gm is not medically necessary.

**Cold/Heat Therapy Unit; rental:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Compensation (TWC); Low Back Procedure Summary, Online Version last updated 5/15/2015.

**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 - Lumbar & Thoracic (Acute & Chronic), Cold packs.

**Decision rationale:** Insufficient testing exists to determine the effectiveness (if any) of heat/cold applications in treating mechanical neck disorders, though due to the relative ease and lack of adverse effects, local applications of cold packs may be applied during first few days of symptoms followed by applications of heat packs to suit patient. The ODG cites no evidence that rotating heat and cold to the lumbar is effective in treating chronic lumbar pain. Hot/Cold therapy machine not medically necessary.

**TENS/EMS Unit; rental:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of TENS.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 68.

**Decision rationale:** The MTUS does not recommend a TENS unit as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration. There is documentation that the patient meets the criteria necessary for a one-month trial of a TENS unit. I am reversing the previous utilization review decision. TENS/EMS unit rental is medically necessary.

**RTW/Functional Capacity Evaluation testing:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Functional Improvement Measures. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Compensation, Fitness for Duty Procedure Summary last updated 3/26/14.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness For Duty, Functional capacity evaluation (FCE).

**Decision rationale:** The Official Disability Guidelines state that a functional capacity evaluation is appropriate if, case management is hampered by complex issues, and the timing is appropriate; such as if the patient is close to being at maximum medical improvement or additional clarification concerning the patient's functional capacity is needed. Functional capacity evaluations are not needed if the sole purpose is to determine a worker's effort or compliance, or the worker has returned to work. There is no documentation in the medical record to support a functional capacity evaluation based on the above criteria. RTW/Functional Capacity Evaluation testing is not medically necessary.

**MRI Lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Compensation, Low Back Procedure Summary, Online Version last updated 5/15/15, indications for magnetic resonance imaging (MRI).

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

**Decision rationale:** The MTUS states that unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. The medical record fails to document sufficient findings indicative of nerve root compromise which would warrant an MRI of the lumbar spine. MRI Lumbar spine is not medically necessary.

**vSNCT 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) Treatment in Workers Compensation, Pain Procedure Summary, Online Version last updated 4/6/15.

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

**Decision rationale:** The MTUS states that unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. The medical record fails to document sufficient findings which would warrant an vSNCT lumbar spine of the lumbar spine. vSNCT lumbar spine is not medically necessary.

**X-rays lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Treatment in Workers Compensation (TWC); Low Back Procedure Summary, Online Version last updated 5/15/15.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

**Decision rationale:** The MTUS states that radiographs of the lumbar spine are indicated when red flags are present indicating fracture, cancer, or infection. The medical record contains no documentation of red flags indicating that a lumbar x-ray is indicated. At present, based on the records provided, and the evidence-based guideline review, the request is non-certified. X-rays lumbar spine is not medically necessary.

**Acupuncture 2 x 6:** Upheld

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

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

**Decision rationale:** The request is for 12 visits of acupuncture. The Chronic Pain Medical Treatment Guidelines allow for an initial 4-6 visits after which time there should be documented functional improvement prior to authorizing more visits. The request for 12 acupuncture visits is more than what is medically necessary to establish whether the treatment is effective. The original reviewer modified the request from 12 visits down to 6 visits. Acupuncture 2 x 6 is not medically necessary.

**Chiropractic 2 x 6:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 58-60.

**Decision rationale:** The request is for 12 visits of chiropractic. The Chronic Pain Medical Treatment Guidelines allow for an initial 4-6 visits after which time there should be documented functional improvement prior to authorizing more visits. The request for 12 chiropractic visits is more than what is medically necessary to establish whether the treatment is effective. The original reviewer modified the request from 12 visits down to 6 visits.

**Physiotherapy 2 x 6:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 58-60.

**Decision rationale:** The MTUS allows for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Prior to full authorization, therapeutic physical therapy is authorized for trial of 6 visits over 2 weeks, with evidence of objective functional improvement prior to authorizing more treatments. There is no documentation of objective functional improvement and the request is for greater than the number of visits necessary for a trial to show evidence of objective functional improvement prior to authorizing more treatments. The original reviewer modified the request from 12 visits down to 6 visits. Physiotherapy 2 x 6 are not medically necessary.

**DNA testing:** 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) Treatment in Workers Compensation, Pain Procedure Summary, Online Version, last updated 4/6/15.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20 - 9792.26 Page(s): 42.

**Decision rationale:** There is currently no evidence-based, peer-reviewed guidelines recommending genetic testing to determine hereditary predisposition to the addiction of narcotics. There is currently no evidence-based guideline supporting that the knowledge of a patient's genetic propensity to addiction would change or guide the treatment in any way. A similar situation using cytokine DNA testing for pain is referenced in the MTUS Chronic Pain guidelines and is not recommended. DNA testing is not medically necessary.