

<b>Case Number:</b>	CM15-0073821		
<b>Date Assigned:</b>	05/20/2015	<b>Date of Injury:</b>	08/06/2008
<b>Decision Date:</b>	07/08/2015	<b>UR Denial Date:</b>	04/08/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/17/2015

### 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: Indiana

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 53-year-old male, who sustained an industrial injury on August 6, 2008. He reported sustaining an electrical shock when hitting a power line with a ladder, losing consciousness, sustaining injury to his low back. The injured worker was diagnosed as having lumbar spine herniated nucleus pulposus (HNP) at L4-L5 and L5-S1 with right greater than left bilateral lower extremity radiculopathy, cervical spine musculoligamentous sprain/strain rule out herniated nucleus pulposus (HNP), bilateral upper extremity radiculopathy, thoracic spine musculoligamentous sprain/strain, annular tear at L5-S1, and Grade 1 spondylolisthesis at L4 on L5. Treatment to date has included cardio-respiratory diagnostic testing, x-rays, physical therapy, MRIs, cortisone injections, home exercise program (HEP), electrodiagnostic studies, CT, and medication. Currently, the injured worker complains of continuous pain in the neck, radiating to the bilateral upper extremities, with numbness and tingling in the bilateral upper extremities, frequent headaches, and stiffness in the neck. The Primary Treating Physician's Orthopedic report dated March 27, 2015, noted the injured worker reported his pain as an 8 on a good day, and 10 on a bad day on a pain scale of 1-10 with 10 being the worse pain. The injured worker's current medications included Align, Probiotic, Mi-Acid, Ranitidine, Citrucel, Gaviscon, Dexilant, Cyclobenzaprine, Sucralfate, Colace, Hyoscyamine, Nortriptyline, Tamsulosin, Trepadone, Sentra AM, and Theramine. Physical examination was noted to show moderate tenderness to palpation over the cervical paravertebral musculature, the thoracic paravertebral musculature, and the lumbar paravertebral musculature. Straight leg raise was positive bilaterally, with +2 hamstring tightness bilaterally, and sensory deficits noted over the bilateral C5, C6, L5, and S1 dermatomes. The treatment plan was noted to include requests for authorization for a lumbar spine high volume epidural steroid injection (ESI) at L5-S1, a cervical spine MRI, with the injured worker given prescriptions for topical cream medications for pain,

muscle spasm, and inflammation, a Kronos Lumbar Pneumatic Brace, and an X-Force Stimulator, with plans for a cervical spine and lumbar spine x-rays at the next visit. The injured worker was noted to be temporarily totally disabled.

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

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

#### **Kronos lumbar pneumatic brace for purchase: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic (Acute & Chronic) chapter, Back braces/lumbar supports.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back ( Lumbar and Thoracic), Lumbar Support.

**Decision rationale:** ACOEM states, Lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. ODG states, not recommended for prevention. Recommended as an option for treatment. See below for indications. Prevention: Not recommended for prevention. There is strong and consistent evidence that lumbar supports were not effective in preventing neck and back pain. (Jellema-Cochrane, 2001) (van Poppel, 1997) (Linton, 2001) (Assendelft-Cochrane, 2004) (van Poppel, 2004) (Resnick, 2005) Lumbar supports do not prevent LBP. (Kinkade, 2007) A systematic review on preventing episodes of back problems found strong, consistent evidence that exercise interventions are effective and other interventions not effective, including stress management, shoe inserts, back supports, ergonomic/back education, and reduced lifting programs. (Bigos, 2009) This systematic review concluded that there is moderate evidence that lumbar supports are no more effective than doing nothing in preventing low-back pain. (van Duijvenbode, 2008). ODG states for use as a treatment: Recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific LBP (very low-quality evidence, but may be a conservative option). The patient is beyond the acute phase of treatment and the treating physician has provided no documentation of spondylolisthesis or documented instability. As such the request is not medically necessary.

#### **X-ray of the 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 Work Loss Data Institute, Lower Back (Lumbar & Thoracic), Corpus Christi,(TX), 2004, 335 p and Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic (Acute & Chronic) chapter, Radiography (X-rays).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Radiography (x-rays).

**Decision rationale:** ACOEM and ODG both agree that 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. The medical notes provided did not document (physical exam, objective testing, or subjective complaints) any red flags for serious spinal pathology or other findings suggestive of the pathologies outlined in the ODG guidelines. ODG additionally states that it may be appropriate when the physician believes it would aid in patient management. The treating physician also does not indicate how the x-ray would aid in patient management. ODG further specifies other indications for imaging with Plain X-rays: Thoracic spine trauma: severe trauma, pain, no neurological deficit. Thoracic spine trauma: with neurological deficit. Lumbar spine trauma (a serious bodily injury): pain, tenderness. Lumbar spine trauma: trauma, neurological deficit. Lumbar spine trauma: seat belt (chance) fracture. Uncomplicated low back pain, trauma, steroids, osteoporosis, over 70Uncomplicated low back pain, suspicion of cancer, infection. Myelopathy (neurological deficit related to the spinal cord), traumatic. Myelopathy, painful. Myelopathy, sudden onset. Myelopathy, infectious disease patient. Myelopathy, oncology patient. Post-surgery: evaluate status of fusion. The treating physician does not indicate any concerns for the above ODG pathologies. As such, the request for x-ray of the lumbar spine is not medically necessary.

**Flurbiprofen 20% cream 120gm:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Compound creams.

**Decision rationale:** MTUS and ODG recommend usage of topical analgesics as an option, but also further details primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The medical documents do not indicate failure of antidepressants or anticonvulsants. MTUS states, there is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. MTUS states that the only FDA- approved NSAID medication for topical use includes Diclofenac, which is indicated for relief of osteoarthritis pain in joints. Flurbiprofen would not be indicated for topical use in this case. Therefore, the request is not medically necessary.

**Gabapentin 10%/Cyclobenzaprine 10%/Capsaicin 0. 0375% cream 120gm:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Compound creams.

**Decision rationale:** MTUS and ODG recommend usage of topical analgesics as an option, but also further details primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The medical documents do not indicate failure of antidepressants or anticonvulsants. MTUS states, there is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. MTUS states that topical Gabapentin is not recommended and further clarifies antiepilepsy drugs: There is no evidence for use of any other

antiepilepsy drug as a topical product. Therefore, the request is not medically necessary.

**Ketoprofen 20%/ Ketamine 10% cream 120gm: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines topical analgesics Page(s): 111-113. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Compound creams.

**Decision rationale:** MTUS and ODG recommend usage of topical analgesics as an option, but also further details primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. The medical documents do not indicate failure of antidepressants or anticonvulsants. MTUS states, there is little to no research to support the use of many of these agents. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Per ODG and MTUS, Ketoprofen is not currently FDA approved for a topical application. It has an extremely high incidence of photocontact dermatitis and photosensitization reactions. Therefore, the request is not medically necessary.