

<b>Case Number:</b>	CM15-0090685		
<b>Date Assigned:</b>	05/18/2015	<b>Date of Injury:</b>	10/07/2013
<b>Decision Date:</b>	09/24/2015	<b>UR Denial Date:</b>	04/14/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	05/11/2015

### 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 63-year-old male, who sustained an industrial injury on 10/07/2013. He has reported subsequent low back and right groin and testicular pain and was diagnosed with sprain of ligaments of the lumbar spine rule out disc displacement, anterolisthesis of L5 over S1, right groin and right testicular pain. Treatment to date has included oral and topical pain medication. In a progress note dated 04/03/2015, the injured worker complained of low back pain and muscle spasms and dull, achy right groin and testicular pain. Objective findings were notable for bilateral lumbar paraspinal muscle guarding, tightness of the bilateral quadratus lumborum muscles, tenderness to palpation of the spinous processes of L3-L5, decreased range of motion of the lumbosacral spine and slightly decreased sensation to pin-prick and light touch at the L4, L5 and S1 dermatomes in the right lower extremity. A request for authorization of pain management consult, electromyogram/nerve conduction study of the bilateral lower extremities, lumbar epidural steroid injection, Deprizine, Dicopanol, Fanatrex, Synapryn, Capsaicin/Flurbiprofen/Gabapentin/Menthol/Camphor compound, Cyclobenzaprine/Gabapentin/Amitriptyline compound, chiropractic treatment 3x6 and physical therapy 3x6 was submitted.

### IMR ISSUES, DECISIONS AND RATIONALES

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

### **Pain Management Consult: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 7: Independent Medical Examinations and Consultations, page 127.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 7, Independent Medical Examinations and Consultations, page 132.

**Decision rationale:** According to the MTUS, a referral request should specify the concerns to be addressed in the independent or expert assessment, including the relevant medical and non-medical issues, diagnosis, causal relationship, prognosis, temporary or permanent impairment, workability, clinical management, and treatment options. The medical record lacks sufficient documentation and does not support a referral request. Pain management consult is not medically necessary.

### **EMG/NCS of the Bilateral Lower Extremities: Upheld**

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

**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) Chapter, Nerve conduction studies (NCS).

**Decision rationale:** According to the Official Disability Guidelines, nerve conduction studies are not recommended. There is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. Neurological testing procedures have limited overall diagnostic accuracy in detecting disc herniation with suspected radiculopathy. EMG/NCS of the Bilateral Lower Extremities is not medically necessary.

### **Lumbar Epidural Steroid Injection: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

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

**Decision rationale:** According to the MTUS, several diagnostic criteria must be present to recommend an epidural steroid injection. The most important criteria are that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. In the therapeutic phase, 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, with a general recommendation of no more than 4 blocks per region per year. The medical record lacks sufficient documentation and does not support a referral request. Lumbar epidural steroid injection is not medically necessary.

**Deprizine:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) Chapter, Compound Drugs.

**Decision rationale:** The requested compound medication contains unnamed and then defined "other proprietary ingredients". In addition, there is no documentation that the patient has a contraindication to medication prescribed in tablet form. According to the Official Disability Guidelines, compounded drugs are not recommended as a first-line therapy. In general, commercially available, FDA-approved drugs should be given an adequate trial. If these are found to be ineffective or are contraindicated in individual patients, compound drugs that use FDA-approved ingredients may be considered. There is no documentation that the FDA approved medication was given an adequate trial. Deprizine is not medically necessary.

**Dicopanol:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) Chapter, Compound Drugs.

**Decision rationale:** The requested compound medication contains unnamed and then defined "other proprietary ingredients". In addition, there is no documentation that the patient has a contraindication to medication prescribed in tablet form. According to the Official Disability Guidelines, compounded drugs are not recommended as a first-line therapy. In general, commercially available, FDA-approved drugs should be given an adequate trial. If these are found to be ineffective or are contraindicated in individual patients, compound drugs that use FDA-approved ingredients may be considered. There is no documentation that the FDA approved medication was given an adequate trial. Dicopanol is not medically necessary.

**Fanatrex:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) Chapter, Compound Drugs.

**Decision rationale:** The requested compound medication contains unnamed and then defined "other proprietary ingredients". In addition, there is no documentation that the patient has a contraindication to medication prescribed in tablet form. According to the Official Disability Guidelines, compounded drugs are not recommended as a first-line therapy. In general, commercially available, FDA-approved drugs should be given an adequate trial. If these are found to be ineffective or are contraindicated in individual patients, compound drugs that use

FDA-approved ingredients may be considered. There is no documentation that the FDA approved medication was given an adequate trial. Dicopanol is not medically necessary.

**Synapryn:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) Chapter, Compound Drugs.

**Decision rationale:** The requested compound medication contains unnamed and then defined "other proprietary ingredients". In addition, there is no documentation that the patient has a contraindication to medication prescribed in tablet form. According to the Official Disability Guidelines, compounded drugs are not recommended as a first-line therapy. In general, commercially available, FDA-approved drugs should be given an adequate trial. If these are found to be ineffective or are contraindicated in individual patients, compound drugs that use FDA-approved ingredients may be considered. There is no documentation that the FDA approved medication was given an adequate trial. Synapryn is not medically necessary.

**Compound: Capsaicin 0.025%, Flurbiprofen 15%, Gabapentin 10%, Menthol 2%, Camphor 2% 180gm:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

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

**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. Flurbiprofen topical is not supported by the MTUS. Compound: Capsaicin 0.025%, Flurbiprofen 15%, Gabapentin 10%, Menthol 2%, Camphor 2% 180gm is not medically necessary.

**Compound: Cyclobenzaprine 2%, Gabapentin 15%, Amitriptyline 10% 180gm:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics 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. There is no evidence for use of any muscle relaxant as a topical product. Gabapentin is not recommended. There is no peer-reviewed literature to support use. Compound: Cyclobenzaprine 2%, Gabapentin 15%, Amitriptyline 10% 180gm is not medically necessary.

**Chiropractic Treatment (18-sessions, 3 times a week for 6-weeks): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-299, Chronic Pain Treatment Guidelines Page(s): 58.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58-60.

**Decision rationale:** The request is for 18 visits of chiropractic. The Chronic Pain Medical Treatment Guidelines allow for initial 4-6 visits after which time there should be documented functional improvement prior to authorizing more visits. The request for 18 chiropractic visits is more than what is medically necessary to establish whether the treatment is effective. Chiropractic Treatment (18-sessions, 3 times a week for 6-weeks) is not medically necessary.

**Physical Therapy (18-sessions, 3 times a week for 6-weeks): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 6: Pain, Suffering and the Restoration of Function, page 114.

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

**Decision rationale:** Therapeutic physical therapy for the low back is recommended by the MTUS as an option with authorization for a trial of 6 visits over 2 weeks, with evidence of objective functional improvement, prior to authorizing more treatments with a total of up to 18 visits over 6-8 weeks. 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. Physical Therapy (18-sessions, 3 times a week for 6-weeks) is not medically necessary.