

<b>Case Number:</b>	CM14-0146745		
<b>Date Assigned:</b>	10/17/2014	<b>Date of Injury:</b>	11/18/2004
<b>Decision Date:</b>	11/19/2014	<b>UR Denial Date:</b>	08/12/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/09/2014

### 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:

According to the records made available for review, this is a 56-year-old male with an 11/18/04 date of injury. At the time (7/11/14) of request for authorization for Gabapentin 10%, Dextromethorphan 10%, Amitriptyline 10%, Flurbiprofen 20%, Tramadol 20%, Cyclobenzaprine 4%, Naproxen Sodium 150 mg #90, Pantoprazole 20 mg #60, MRI study - lumbar spine, NCV-right lower extremity, NCV-left lower extremity, EMG study - right lower extremity, EMG study - left lower extremity, and functional capacity evaluation, there is documentation of subjective (chronic severe low back pain radiating to the legs) and objective (spasm over the lumbar spine with decreased range of motion, positive straight leg raise, and mildly decreased strength of the L5 and S1 dermatome) findings. EMG/NCV of the bilateral lower extremities (3/19/12) report revealed left peroneal neuropathy, possible S1 radiculopathy, and possible left peroneal or psychiatric neuropathy, or left L4, L5, S1 radiculopathy. MRI of the lumbar spine (3/20/12) report revealed combined degenerative and facet change resulting in moderate central canal and bilateral foraminal stenosis at L5-S1). The current diagnosis is lumbar spine strain. The treatment to date includes ongoing therapy with Naproxen and physical modalities. Medical report identifies a request for acupuncture and chiropractic therapy. Regarding Naproxen Sodium 150 mg #90, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Naproxen use to date. Regarding Pantoprazole 20 mg #60, there is no documentation of risk for gastrointestinal event (high dose/multiple NSAID) and that Pantoprazole is being used as second-line therapy after failure of first-line proton pump inhibitor therapy (Omeprazole or Lansoprazole). Regarding MRI study - lumbar spine, there is no documentation of a diagnosis/condition (with supportive subjective/objective findings) for which a repeat study is indicated (to diagnose a change in the patient's condition

marked by new or altered physical findings). Regarding NCV-right lower extremity, NCV-left lower extremity, EMG study - right lower extremity, and EMG study - left lower extremity, there is no documentation of an interval injury or progressive neurologic findings, failure of conservative treatment, and that the etiology of the radicular symptoms is not explained by MRI. Regarding functional capacity evaluation, there is no documentation indicating case management is hampered by complex issues (prior unsuccessful RTW attempts, conflicting medical reporting on precautions and/or fitness for modified job, injuries that require detailed exploration of a worker's abilities); and timing is appropriate (Close to or at MMI/all key medical reports secured and additional/secondary conditions have been clarified).

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

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

**Gabapentin 10%, Dexamethorphan 10%, Amitriptyline 10%: Upheld**

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

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

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies that many agents are compounded as monotherapy or in combination for pain control; that Ketoprofen, Lidocaine (in creams, lotion or gels), Capsaicin in a 0.0375% formulation, Baclofen and other muscle relaxants, and Gabapentin and other anti-epilepsy drugs are not recommended for topical applications; and that any compounded product that contains at least one drug (or drug class) that is not recommended, is not recommended. Within the medical information available for review, there is documentation of a diagnosis of lumbar spine strain. However, the requested compounded medication consists of at least one drug (Gabapentin) that is not recommended. Therefore, based on guidelines and a review of the evidence, the request for Gabapentin 10%, Dextromethorphan 10%, Amitriptyline 10% is not medically necessary.

**Flurbiprofen 20%, Tramadol 20%, Cyclobenzaprine 4%: Upheld**

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

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

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies that many agents are compounded as monotherapy or in combination for pain control; that Ketoprofen, Lidocaine (in creams, lotion or gels), Capsaicin in a 0.0375% formulation, Baclofen and other muscle relaxants, and Gabapentin and other anti-epilepsy drugs are not recommended for topical applications; and that any compounded product that contains at least one drug (or drug class) that is not recommended, is not recommended. Within the medical information available for review,

there is documentation of a diagnosis of lumbar spine strain. However, the requested compounded medication consists of at least one drug class (muscle relaxants) that is not recommended. Therefore, based on guidelines and a review of the evidence, the request for Flurbiprofen 20%, Tramadol 20%, Cyclobenzaprine 4% is not medically necessary.

**Naproxen Sodium 150 mg #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-68. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of moderate to severe osteoarthritis pain, acute low back pain, chronic low back pain, or exacerbations of chronic pain, as criteria necessary to support the medical necessity of NSAIDs. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of a diagnosis of lumbar spine strain. In addition, there is documentation of chronic low back pain. However, given documentation of ongoing treatment with Naproxen, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications as a result of Naproxen use to date. Therefore, based on guidelines and a review of the evidence, the request for Naproxen Sodium 150 mg #90 is not medically necessary.

**Pantoprazole 20 mg #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms & cardiovascular risk Page(s): 68-69. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Proton pump inhibitors (PPIs) Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies that risk for gastrointestinal event includes age > 65 years; history of peptic ulcer, GI bleeding or perforation; concurrent use of ASA, corticosteroids, and/or an anticoagulant; and/or high dose/multiple NSAID. Official Disability Guidelines identifies documentation of risk for gastrointestinal events, preventing gastric ulcers induced by NSAIDs, and that Pantoprazole is being used as second-line therapy after failure of first-line proton pump inhibitor therapy (such as Omeprazole

or Lansoprazole), as criteria necessary to support the medical necessity of proton pump inhibitors. Within the medical information available for review, there is documentation of a diagnosis of lumbar spine strain. However, despite documentation of chronic NSAID therapy, there is no documentation of risk for gastrointestinal event (high dose/multiple NSAID). In addition, there is no documentation that Pantoprazole is being used as second-line therapy after failure of first-line proton pump inhibitor therapy (Omeprazole or Lansoprazole). Therefore, based on guidelines and a review of the evidence, the request for Pantoprazole 20 mg #60 is not medically necessary.

**MRI study - 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, Low Back - Lumbar & Thoracic (Acute & Chronic), Indications for imaging - Magnetic resonance imaging

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation Other Medical Treatment Guidelines: Official Disability Guidelines (ODG) Minnesota Rules, 5221.6100 Parameters for Medical Imaging

**Decision rationale:** MTUS reference to ACOEM guidelines identifies documentation of red flag diagnoses where plain film radiographs are negative; objective findings that identify specific nerve compromise on the neurologic examination, failure of conservative treatment, and who are considered for surgery, as criteria necessary to support the medical necessity of MRI. Official Disability Guidelines identifies documentation of a diagnosis/condition (with supportive subjective/objective findings) for which a repeat study is indicated (such as: To diagnose a suspected fracture or suspected dislocation, to monitor a therapy or treatment which is known to result in a change in imaging findings and imaging of these changes are necessary to determine the efficacy of the therapy or treatment (repeat imaging is not appropriate solely to determine the efficacy of physical therapy or chiropractic treatment), to follow up a surgical procedure, to diagnose a change in the patient's condition marked by new or altered physical findings) as criteria necessary to support the medical necessity of a repeat MRI. Within the medical information available for review, there is documentation of a diagnosis of lumbar spine strain. In addition, there is documentation of a previous lumbar MRI performed on 3/20/12. However, despite documentation of subjective (chronic severe low back pain radiating to the legs) and objective (spasm over the lumbar spine with decreased range of motion, positive straight leg raise, and mildly decreased strength of the L5 and S1 dermatome) findings, there is no documentation of a diagnosis/condition (with supportive subjective/objective findings) for which a repeat study is indicated (to diagnose a change in the patient's condition marked by new or altered physical findings). Therefore, based on guidelines and a review of the evidence, the request for MRI study of the lumbar spine is not medically necessary.

**NCV - right lower extremity:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic): Electrodiagnostic studies (EDS)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Electrodiagnostic studies Other Medical Treatment Guideline or Medical Evidence: Nerve Conduction Velocity Studies ([http://www.aetna.com/cpb/medical/data/500\\_599/0502.html](http://www.aetna.com/cpb/medical/data/500_599/0502.html))

**Decision rationale:** MTUS reference to ACOEM guidelines identifies documentation of focal neurologic dysfunction in patients with low back symptoms lasting more than three to four weeks, as criteria necessary to support the medical necessity of electrodiagnostic studies. Official Disability Guidelines identifies documentation of evidence of radiculopathy after 1-month of conservative therapy, as criteria necessary to support the medical necessity of electrodiagnostic studies. In addition, Official Disability Guidelines does not consistently support performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. Medical Treatment Guideline necessitates documentation of an interval injury or progressive neurologic findings to support the medical necessity of a repeat study. Within the medical information available for review, there is documentation of a diagnosis of lumbar spine strain. In addition, there is documentation of previous electrodiagnostic studies (EMG/NCV of the bilateral lower extremities) performed on 3/19/12. However, despite documentation of subjective (chronic severe low back pain radiating to the legs) and objective (spasm over the lumbar spine with decreased range of motion, positive straight leg raise, and mildly decreased strength of the L5 and S1 dermatome) findings, there is no documentation of an interval injury or progressive neurologic findings. In addition, given documentation of a request for acupuncture and chiropractic therapy, there is no documentation of failure of conservative treatment. Therefore, based on guidelines and a review of the evidence, the request for NCV of the right lower extremity is not medically necessary.

**NCV - left lower extremity:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic): Electrodiagnostic studies (EDS)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Electrodiagnostic studies Other Medical Treatment Guideline or Medical Evidence: Nerve Conduction Velocity Studies ([http://www.aetna.com/cpb/medical/data/500\\_599/0502.html](http://www.aetna.com/cpb/medical/data/500_599/0502.html))

**Decision rationale:** MTUS reference to ACOEM guidelines identifies documentation of focal neurologic dysfunction in patients with low back symptoms lasting more than three to four weeks, as criteria necessary to support the medical necessity of electrodiagnostic studies. Official Disability Guidelines identifies documentation of evidence of radiculopathy after 1-month of conservative therapy, as criteria necessary to support the medical necessity of electrodiagnostic studies. In addition, Official Disability Guidelines does not consistently support performing

nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. Medical Treatment Guideline necessitates documentation of an interval injury or progressive neurologic findings to support the medical necessity of a repeat study. Within the medical information available for review, there is documentation of a diagnosis of lumbar spine strain. In addition, there is documentation of previous electrodiagnostic studies (EMG/NCV of the bilateral lower extremities) performed on 3/19/12. However, despite documentation of subjective (chronic severe low back pain radiating to the legs) and objective (spasm over the lumbar spine with decreased range of motion, positive straight leg raise, and mildly decreased strength of the L5 and S1 dermatome) findings, there is no documentation of an interval injury or progressive neurologic findings. In addition, given documentation of a request for acupuncture and chiropractic therapy, there is no documentation of failure of conservative treatment. Therefore, based on guidelines and a review of the evidence, the request for NCV of the left lower extremity is not medically necessary.

**Electromyography (EMG) study - right lower extremity:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Electrodiagnostic studies Other Medical Treatment Guideline or Medical Evidence: Nerve Conduction Velocity Studies ([http://www.aetna.com/cpb/medical/data/500\\_599/0502.html](http://www.aetna.com/cpb/medical/data/500_599/0502.html))

**Decision rationale:** MTUS reference to ACOEM guidelines identifies documentation of focal neurologic dysfunction in patients with low back symptoms lasting more than three to four weeks, as criteria necessary to support the medical necessity of electrodiagnostic studies. Official Disability Guidelines identifies documentation of evidence of radiculopathy after 1-month of conservative therapy, as criteria necessary to support the medical necessity of electrodiagnostic studies. Medical Treatment Guideline necessitates documentation of an interval injury or progressive neurologic findings to support the medical necessity of a repeat study. Within the medical information available for review, there is documentation of a diagnosis of lumbar spine strain. In addition, there is documentation of previous electrodiagnostic studies (EMG/NCV of the bilateral lower extremities) performed on 3/19/12. However, despite documentation of subjective (chronic severe low back pain radiating to the legs) and objective (spasm over the lumbar spine with decreased range of motion, positive straight leg raise, and mildly decreased strength of the L5 and S1 dermatome) findings, there is no documentation of an interval injury or progressive neurologic findings. In addition, given documentation of a request for acupuncture and chiropractic therapy, there is no documentation of failure of conservative treatment. Furthermore, given documentation of a previous lumbar MRI identifying combined degenerative and facet change resulting in moderate central canal and bilateral foraminal stenosis at L5-S1), there is no documentation that the etiology of the radicular symptoms is not explained by MRI. Therefore, based on guidelines and a review of the evidence, the request for EMG study of the right lower extremity is not medically necessary.

**EMG study - left lower extremity:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Electrodiagnostic studies Other Medical Treatment Guideline or Medical Evidence: Nerve Conduction Velocity Studies ([http://www.aetna.com/cpb/medical/data/500\\_599/0502.html](http://www.aetna.com/cpb/medical/data/500_599/0502.html))

**Decision rationale:** MTUS reference to ACOEM guidelines identifies documentation of focal neurologic dysfunction in patients with low back symptoms lasting more than three to four weeks, as criteria necessary to support the medical necessity of electrodiagnostic studies. Official Disability Guidelines identifies documentation of evidence of radiculopathy after 1-month of conservative therapy, as criteria necessary to support the medical necessity of electrodiagnostic studies. Medical Treatment Guideline necessitates documentation of an interval injury or progressive neurologic findings to support the medical necessity of a repeat study. Within the medical information available for review, there is documentation of a diagnosis of lumbar spine strain. In addition, there is documentation of previous electrodiagnostic studies (EMG/NCV of the bilateral lower extremities) performed on 3/19/12. However, despite documentation of subjective (chronic severe low back pain radiating to the legs) and objective (spasm over the lumbar spine with decreased range of motion, positive straight leg raise, and mildly decreased strength of the L5 and S1 dermatome) findings, there is no documentation of an interval injury or progressive neurologic findings. In addition, given documentation of a request for acupuncture and chiropractic therapy, there is no documentation of failure of conservative treatment. Furthermore, given documentation of a previous lumbar MRI identifying combined degenerative and facet change resulting in moderate central canal and bilateral foraminal stenosis at L5-S1), there is no documentation that the etiology of the radicular symptoms is not explained by MRI. Therefore, based on guidelines and a review of the evidence, the request for EMG study of the left lower extremity is not medically necessary.

**Functional capacity evaluation:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004), Chapter 7, Independent Medical Examinations and Consultations and Official Disability Guidelines, Fitness for Duty Chapter, Procedure Summary, Functional capacity evaluation (FCE)

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Independent Medical Examinations and Consultations, page(s) 137-138 Official Disability Guidelines (ODG) Fitness For Duty, Functional capacity evaluation (FCE)

**Decision rationale:** MTUS reference to ACOEM guidelines identifies that functional capacity evaluations (FCE) may establish physical abilities and also facilitate the examinee/employer

relationship for return to work. Official Disability Guidelines identifies documentation indicating case management is hampered by complex issues (prior unsuccessful RTW attempts, conflicting medical reporting on precautions and/or fitness for modified job, injuries that require detailed exploration of a worker's abilities); and timing is appropriate (Close to or at MMI/all key medical reports secured and additional/secondary conditions have been clarified), as criteria necessary to support the medical necessity of a functional capacity evaluation. Within the medical information available for review, there is documentation of a diagnosis of lumbar spine strain. However, there is no documentation indicating case management is hampered by complex issues (prior unsuccessful RTW attempts, conflicting medical reporting on precautions and/or fitness for modified job, injuries that require detailed exploration of a worker's abilities); and timing is appropriate (Close to or at MMI/all key medical reports secured and additional/secondary conditions have been clarified). Therefore, based on guidelines and a review of the evidence, the request for functional capacity evaluation is not medically necessary.