Case Number:	CM16-0248698		
Date Assigned:	01/04/2017	**Date of Injury:**	10/26/2016
Decision Date:	02/02/2017	**UR Denial Date:**	12/23/2016
Priority:	Standard	**Application Received:**	12/28/2016

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: Texas, New York
Certification(s)/Specialty: Physical Medicine & Rehabilitation, Sports 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:

This case involves a now 39-year-old male with a history of an occupational claim from 10/18/2016. The mechanism of injury is detailed as cumulative trauma. The current diagnosis is documented as sprain of ligaments of lumbar spine, subsequent encounter. On 11/15/2016, the patient reported pain in the low back, and right hip rated 7/10 on VAS. Physical exam revealed tenderness at the right butt sciatic area radiating to the right thigh. There was muscle spasm, and trigger points noted. There was lumbar, and hip decreased range of motion. There was tenderness to palpation at the right trochanter. There was decreased sensation in the L4-S1 distribution. Motor strength was 4/5 in the bilateral lower extremities. Deep tendon reflexes were 2+, and symmetrical in the lower extremities. Treatment plan included prescribed medications, and imaging studies. A Request for Authorization was not provided. The original utilization review dated 12/23/2016 denied the request for imaging studies due to there was no evidence of red flag conditions or trialed and failed conservative care. The request for acupuncture was modified to allow for 6 sessions as recommended by the guidelines. The request for Functional Capacity Evaluation was denied due to the patient's current work status was not provided. The request for electrodiagnostic studies were denied due to there was no rationale provided as to the medical necessity for this request. The request for compound drugs was denied due to there was no evidence the patient has trialed and failed first line treatment. Additionally, the guidelines do not recommend compound drugs. The request for topical compound medications were denied due to there was no documentation of failed first line therapy. Additionally, the guidelines do not recommend compound topical creams. The request for Prilosec was denied due to there was no

documentation of gastrointestinal symptoms. Additionally, the use of 2 proton pump inhibitors was not supported. The request for celecoxib was denied due to rationale for high dose of celecoxib was not provided. The request for venlafaxine was denied due to there is no documentation of depressive symptoms for which the antidepressant is medically indicated.

IMR ISSUES, DECISIONS AND RATIONALES

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

X-rays lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

Decision rationale: The ACOEM Guidelines state, 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 6 weeks. Based on the clinical notes submitted for review, there is a lack of rationale provided by the physician as to the medical necessity for initial extensive imaging studies. There is no documentation of trialed and failed conservative care prior to proceeding with imaging studies. Physical examination revealed no evidence of red flag conditions which would warrant suspicion of serious spinal pathology for the requested imaging study. Given the above, the request for "X-rays lumbar spine" is not medically necessary.

X-rays of right hip: Upheld

Claims Administrator guideline: The Claims Administrator based their decision on recommendation(s) outside of the MTUS Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Hip and Pelvis.

MAXIMUS guideline: The Expert Reviewer based their decision on recommendation(s) outside of the MTUS Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip & Pelvis, X-Ray.

Decision rationale: The California MTUS and ACOEM Guidelines do not address. The Official Disability Guidelines recommend x-ray for patients who sustain severe injury and patients with a high risk of developing hip osteoarthritis. There is a lack of rationale provided by the physician as to the medical necessity for this request. There is no indication the patient has trialed and failed conservative care to include physical therapy and NSAIDs. Physical examination revealed no evidence of red flag conditions to include fracture and/or osteoarthritis. Given the above, the request for "X-rays of right hip" is not medically necessary.

Acupuncture 18 sessions was the original request. Acupuncture 6 sessions was authorized by the Claims Administrator. The remaining IMR eligible portion of the original request, Acupuncture 12 sessions is: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment 2007.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment 2007.

Decision rationale: The California MTUS Acupuncture Guidelines recommend acupuncture as an option when pain medication is reduced or not tolerated and may be used as an adjunct to physical rehabilitation and/or surgical intervention. There is a lack of rationale provided by the physician as to the medical necessity for this request. There is no evidence the patient is unable to tolerate pain medication or the pain medication is being reduced. Additionally, the patient was authorized 6 sessions by previous reviewer. Additional treatment is contingent upon patient response to therapy. Given the above, Acupuncture 12 sessions is not medically necessary.

Functional capacity evaluation (FCE): Upheld

Claims Administrator guideline: The Claims Administrator based their decision on recommendation(s) outside of the MTUS Guidelines. Decision based on Non-MTUS Citation ACOEM Guidelines, Chapter 7, Independent Medical Examinations and Consultations, page 137.

MAXIMUS guideline: Decision based on MTUS General Approaches 2004, Section(s): General Approach to Initial Assessment and Documentation.

Decision rationale: The ACOEM Guidelines recommend considering using a Functional Capacity Evaluation when necessary to translate medical impairment into functional limitations, and determine work capability. There is a lack of rationale provided by the physician as to the medical necessity for this request. There is no documentation of trialed and failed conservative care to include physical therapy, and medications. Physical examination findings revealed no evidence to support the patient is not able to currently continue his regular work duties. The patient was recommended to return to regular work duties on 11/15/2016 with no limitations or restrictions. Medical necessity for a Functional Capacity Evaluation is not substantiated at this time. Given the above, the request for "Functional capacity evaluation (FCE)" is not medically necessary.

MARS MRI scan of lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

Decision rationale: The ACOEM Guidelines state, 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. Based on the clinical notes submitted for review, physical exam of the lumbar spine revealed no evidence of red flag conditions and/or nerve compromise to warrant the requested treatment. There was a lack of rationale provided by the physician as to the medical necessity for this request. Furthermore, there is no evidence the patient has trialed and failed conservative care to include physical therapy prior to this request. Given the above, the request for "MARS MRI scan of lumbar spine" is not medically necessary.

MARS MRI scan of right hip: Upheld

Claims Administrator guideline: The Claims Administrator based their decision on recommendation(s) outside of the MTUS Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Hip and Pelvis.

MAXIMUS guideline: The Expert Reviewer based their decision on recommendation(s) outside of the MTUS Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip & Pelvis, MRI (magnetic resonance imaging).

Decision rationale: The California MTUS/ACOEM Guidelines do not address. The Official Disability Guidelines state, an MRI is the most accepted form of imaging for finding avascular necrosis of the hip and osteonecrosis. There is a lack of rationale provided by the physician as to the medical necessity for the request. Physical examination findings revealed no evidence of red flag conditions to suspect necrosis of the hip and osteonecrosis. There is no evidence of severe injury. There is no physical examination findings to suspect labral tears and/or acute and chronic soft tissue injuries. There is no documentation the patient has trialed and failed conservative care to include physical therapy, and NSAIDs prior to this request. Given the above, the request for "MARS MRI scan of right hip" is not medically necessary.

EMG bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2016, Section(s): Electrodiagnostic testing (EMG/NCS).

Decision rationale: The California MTUS 2016 Chronic Pain Guidelines state, electromyography and nerve conduction studies are separate studies, and should not necessarily be done together. Nerve conduction studies are not recommended, but electromyography is recommended as an option to obtain unequivocal evidence of radiculopathy after a one month conservative therapy, but electromyography is not necessary if radiculopathy is already clinically obvious. There is a lack of evidence based rationale provided by the physician as to the medical necessity for this request. There is no evidence the patient has trialed and failed conservative care to include physical therapy, and NSAIDs prior to this request. The physician did not provide a

clear rationale as to the medical necessity for electro diagnostic studies at this time, and how results would affect the patient's current treatment plan. Given the above, the request for "EMG bilateral lower extremities" is not medically necessary.

NCV bilateral lower extremities QTY: 2: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2016, Section(s): Electrodiagnostic testing (EMG/NCS).

Decision rationale: The California MTUS 2016 Chronic Pain Guidelines state, electromyography and nerve conduction studies are separate studies, and should not necessarily be done together. Nerve conduction studies are not recommended, but electromyography is recommended as an option to obtain unequivocal evidence of radiculopathy after a one month conservative therapy, but electromyography is not necessary if radiculopathy is already clinically obvious. There is a lack of evidence based rationale provided by the physician as to the medical necessity for this request. There is no evidence the patient has trialed and failed conservative care to include physical therapy, and NSAIDs prior to this request. The physician did not provide a clear rationale as to the medical necessity for electro diagnostic studies at this time, and how results would affect the patient's current treatment plan. Given the above, the request for "NCV bilateral lower extremities QTY: 2" is not medically necessary.

Deprizine (unknown quantity): Upheld

Claims Administrator guideline: The Claims Administrator based their decision on recommendation(s) outside of the MTUS Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2016, Section(s): Compound drugs.

Decision rationale: The California MTUS 2016 Chronic Pain Guidelines do not recommend compound drugs as a first line therapy. There was no clear rationale provided by the physician as to the medical necessity for the request. There is no indication the patient is not able to tolerate similar medication in pill/tablet form. The patient's current medication regimen was not provided. There is no evidence to support the patient has failed first line therapy prior to this request. Given the above, the request for Deprizine (unknown quantity) is not medically necessary.

Fanatrex (unknown quantity): Upheld

Claims Administrator guideline: The Claims Administrator based their decision on recommendation(s) outside of the MTUS Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2016, Section(s): Compound drugs.

Decision rationale: The California MTUS 2016 Chronic Pain Guidelines do not recommend compound drugs as a first line therapy. There was no clear rationale provided by the physician as to the medical necessity for the request. There is no indication the patient is not able to tolerate similar medication in pill/tablet form. The patient's current medication regimen was not provided. There is no evidence to support the patient has failed first line therapy prior to this request. Given the above, the request for Fanatrex (unknown quantity) is not medically necessary.

Synapryn (unknown quantity): Upheld

Claims Administrator guideline: The Claims Administrator based their decision on recommendation(s) outside of the MTUS Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2016, Section(s): Compound drugs, and Opioid Treatment 2016, Section(s): 3.3 Opioids for Chronic Pain and Chronic Opioid Treatment: Initiating and Monitoring Chronic Opioid Treatment.

Decision rationale: The California MTUS 2016 Chronic Pain Guidelines do not recommend compound drugs as a first line therapy. There was no clear rationale provided by the physician as to the medical necessity for the request. There is no indication the patient is not able to tolerate similar medication in pill/tablet form. The patient's current medication regimen was not provided. There is no evidence to support the patient has failed first line therapy to include non-opioid analgesics prior to this request. Moreover, a CURES report was not checked, and documented prior to prescribing this medication. There is no evidence an opioid risk assessment was completed. Given the above, the request for Synapryn (unknown quantity) is not medically necessary. This decision addresses the medical necessity of opioids as they have been prescribed to this patient. This medical necessity decision should not be interpreted as a recommendation to stop long-term opioids abruptly and the patient is advised to speak with their treating physician. The treating physician and the patient are advised to consult the MTUS Opioids Treatment Guidelines ("Tapering opioids"), and if necessary, other relevant guidelines, regarding the most appropriate method for weaning and terminating opioids for this patient.

Tabradol (unknown quantity): Upheld

Claims Administrator guideline: The Claims Administrator based their decision on recommendation(s) outside of the MTUS Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2016, Section(s): Compound drugs.

Decision rationale: The California MTUS 2016 Chronic Pain Guidelines do not recommend compound drugs as a first line therapy. There was no clear rationale provided by the physician as to the medical necessity for the request. There is no indication the patient is not able to tolerate similar medication in pill/tablet form. The patient's current medication regimen was not provided. There is no evidence to support the patient has failed first line therapy prior to this request. Given the above, the request for Tabradol (unknown quantity) is not medically necessary.

Ketophene (unknown quantity): Upheld

Claims Administrator guideline: The Claims Administrator based their decision on recommendation(s) outside of the MTUS Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2016, Section(s): Compound drugs.

Decision rationale: The California MTUS 2016 Chronic Pain Guidelines do not recommend compound drugs as a first line therapy. There was no clear rationale provided by the physician as to the medical necessity for the request. There is no indication the patient is not able to tolerate similar medication in pill/tablet form. The patient's current medication regimen was not provided. There is no evidence to support the patient has failed first line therapy prior to this request. Given the above, the request for Ketophene (unknown quantity) is not medically necessary.

Ketoprofen 20% in cream base 240g: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2016, Section(s): Topical analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2016, Section(s): Topical analgesics.

Decision rationale: The California MTUS 2016 Chronic Pain Guidelines recommend topical NSAIDs for acute pain and osteoarthritis pain for joints that lend themselves to topical treatment. There is a lack of evidence based rationale provided by the physician as to the medical necessity for this request. There is no evidence the patient cannot tolerate pain medication in oral form to warrant topical treatment. There are there are no exceptional factors noted within the documentation which would demonstrate medical necessity for the requested treatment outside of the recommended guidelines. Given the above, the request for "Ketoprofen 20% in cream base 240g" is not medically necessary.

Cyclobenzaprine 5% in cream base 240g: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2016, Section(s): Topical analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2016, Section(s): Topical analgesics.

Decision rationale: The California MTUS 2016 Chronic Pain Guidelines recommend topical analgesics for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Topical muscle relaxants are not recommended. There are no exceptional factors noted within the documentation which would demonstrate medical necessity for the requested treatment outside of the recommended guidelines. There is no evidence the patient has trialed and failed first line therapy. There is no evidence the patient cannot tolerate similar medication in oral form. Given the above, the request for "Cyclobenzaprine 5% in cream base 240g" is not medically necessary.

Bupropion HCL 150mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2016 Guidelines, Section(s): Bupropion (Wellbutrin®).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2016 Guidelines, Section(s): Antidepressants for chronic pain.

Decision rationale: The California MTUS 2016 Chronic Pain Guidelines recommend antidepressants for chronic pain as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. It is unclear if this is a first time prescription or ongoing management. There was no clear rationale provided by the physician as to the medical necessity for continued treatment with said medication. There is no evidence the patient is benefiting from treatment. There is no documentation of pain relief in terms of VAS with use of the medication, improved symptoms of depression/anxiety, and objective functional improvement to include quality of life. Review of systems revealed no evidence of depression associated with chronic pain. It is noted the patient complained of "feeling micromanaged." No other supporting evidence was provided. Given the above, the request for "Bupropion HCL 150mg #90" is not medically necessary.

Prilosec 20mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2016 Guidelines, Section(s): Proton Pump Inhibitors (PPIs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2016 Guidelines, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: The California MTUS 2016 Chronic Pain Guidelines recommend H2-receptor antagonists or a proton pump inhibitor for patients at risk for developing a gastrointestinal event or symptoms of dyspepsia secondary to NSAID therapy. There was a lack of evidence provided to support medication efficacy. Medical necessity for continued treatment was not provided. There is a lack of history of peptic ulcer, GI bleeding, or perforation. There is

no indication the patient is on a high dose/multiple NSAID use to warrant treatment. Given the above, the request for Prilosec 20mg #90 is not medically necessary.

Pantoprazole sodium 20mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2016 Guidelines, Section(s): Proton Pump Inhibitors (PPIs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2016 Guidelines, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: The California MTUS 2016 Chronic Pain Guidelines recommend H2-receptor antagonists or a proton pump inhibitor for patients at risk for developing a gastrointestinal event or symptoms of dyspepsia secondary to NSAID therapy. There was a lack of evidence provided to support medication efficacy. Medical necessity for continued treatment was not provided. There is a lack of history of peptic ulcer, GI bleeding, or perforation. There is no indication the patient is on a high dose/multiple NSAID use to warrant treatment. Given the above, the request for Pantoprazole sodium 20mg #60 is not medically necessary.

Celecoxib 200mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2016 Guidelines, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2016 Guidelines, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

Decision rationale: The California MTUS 2016 Chronic Pain Guidelines recommend NSAIDs at the lowest dose for the shortest period in patients with moderate to severe pain. There is no clear rationale provided as to the medical necessity for continued treatment. There was no documentation of pain relief in terms of VAS with use of the medication, and objective functional improvement to include activities of daily living. It is unclear if this is a first time request or ongoing treatment. Given the above, the request for Celecoxib 200mg #90 is not medically necessary.

Venlafaxine HCL ER 37.5mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2016 Guidelines, Section(s): Antidepressants for chronic pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2016 Guidelines, Section(s): Antidepressants for chronic pain.

Decision rationale: The California MTUS 2016 Chronic Pain Guidelines recommend antidepressants for chronic pain as a first line option for neuropathic pain, and as a possibility for non-neuropathic pain. It is unclear if this is a first time prescription or ongoing management.

There was no clear rationale provided by the physician as to the medical necessity for continued treatment with said medication. There is no evidence the patient is benefiting from treatment. There is no documentation of pain relief in terms of VAS with use of the medication, improved symptoms of depression/anxiety, and objective functional improvement to include quality of life. Review of systems revealed no evidence of depression associated with chronic pain. It is noted the patient complained of "feeling micromanaged." No other supporting evidence was provided. Given the above, the request for Venlafaxine HCL ER 37.5mg #90 is not medically necessary.

Dicopanol (unknown quantity): Upheld

Claims Administrator guideline: The Claims Administrator based their decision on recommendation(s) outside of the MTUS Guidelines. Decision based on Non-MTUS Official Disability Guidelines (ODG), Pain.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2016 Guidelines, Section(s): Compound drugs.

Decision rationale: The California MTUS 2016 Chronic Pain Guidelines do not recommend compound drugs as a first line therapy. There was no clear rationale provided by the physician as to the medical necessity for the request. There is no indication the patient is not able to tolerate similar medication in pill/tablet form. The patient's current medication regimen was not provided. There is no evidence to support the patient has failed first line therapy prior to this request. Given the above, the request for Dicopanol (unknown quantity) is not medically necessary.