

Case Number:	CM13-0016401		
Date Assigned:	03/03/2014	Date of Injury:	05/24/2003
Decision Date:	04/14/2014	UR Denial Date:	08/20/2013
Priority:	Standard	Application Received:	08/26/2013

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 Hawaii. 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:

This patient is a 44-year-old male with a date of injury of 5/24/2003. Medical records indicate the patient is undergoing treatment for chronic low back pain with radiculitis. Treatment has included physical therapy (9 visits) and chiropractic treatment (24 visits). Physical exam findings include spasms and tenderness of the lumbar spine, but no 'red flags' were indicated by the treating physician. Medical documentation did not include medication list or radiological procedures performed. A utilization review dated 8/20/2013 non-certified a request for MRI lumbar spine, x-ray lumbar spine, acupuncture 2x6 lumbar, chiropractor and physiotherapy 3x4 lumbar, and Lidoderm patch 5% bid #60.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI OF THE LUMBAR SPINE: 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): 287-315.

Decision rationale: The Expert Reviewer's decision rationale: MTUS and ACOEM recommend MRI, in general, for low back pain when "cuada equine, tumor, infection, or fracture are strongly

suspected and plain film radiographs are negative, MRI test of choice for patients with prior back surgery" ACOEM additionally recommends against MRI for low back pain "before 1 month in absence of red flags". ODG states, "Imaging is indicated only if they have severe progressive neurologic impairments or signs or symptoms indicating a serious or specific underlying condition, or if they are candidates for invasive interventions. Immediate imaging is recommended for patients with major risk factors for cancer, spinal infection, cauda equina syndrome, or severe or progressive neurologic deficits. Imaging after a trial of treatment is recommended for patients who have minor risk factors for cancer, inflammatory back disease, vertebral compression fracture, radiculopathy, or symptomatic spinal stenosis. Subsequent imaging should be based on new symptoms or changes in current symptoms." The medical notes provided did not document (physical exam, objective testing, or subjective complaints) any red flags, significant worsening in symptoms or other findings suggestive of the pathologies outlined in the above guidelines. As such, the request for MRI lumbar spine is not medically necessary.

X-RAYS OF THE LUMBAR SPINE: 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): 287-315. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) LOW BACK - LUMBAR & THORACIC (ACUTE & CHRONIC), RADIOGRAPHY (X-RAYS)

Decision rationale: MTUS 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 70 Uncomplicated 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.

ACUPUNCTURE FOR THE LUMBAR SPINE, 2 X PER WEEK FOR 6 WEEKS, FOR A TOTAL OF 12 SESSIONS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) LOW BACK-LUMBAR & THORACIC (ACUTE & CHRONIC), ACUPUNCTURE

Decision rationale: The Expert Reviewer's decision rationale: MTUS "Acupuncture Medical Treatment Guidelines" clearly state that "acupuncture is used as an option when pain medication is reduced or not tolerated; it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery." The medical documents did not provide detail regarding patient's increase or decrease in pain medication. Further, there was no evidence to support that this treatment would be utilized as an adjunct to physical rehabilitation or surgical intervention to hasten functional recovery. ODG does not recommend acupuncture for acute low back pain, but "may want to consider a trial of acupuncture for acute LBP if it would facilitate participation in active rehab efforts." The initial trial should "3-4 visits over 2 weeks with evidence of objective functional improvement, total of up to 8-12 visits over 4-6 weeks (Note: The evidence is inconclusive for repeating this procedure beyond an initial short course of therapy.)" There is no evidence provided that indicates the patient received acupuncture before or that the acupuncture sessions are being used as an adjunct to physical rehabilitation or surgical intervention. Additionally, the request for 12 initial sessions is in excess of the recommended trial by ODG. As such, the request for acupuncture for 2 times a week for 6 weeks is not medically necessary.

CHIROPRACTIC TREATMENT FOR THE LUMBAR SPINE, 3 X PER WEEK FOR 4 WEEKS, FOR A TOTAL OF 12 SESSIONS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MANUAL THERAPY & MANIPULATION Page(s): 58-60. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES LOW BACK-LUMBAR & THORACIC.

Decision rationale: ODG recommends chiropractic treatment as an option for acute low back pain, but additionally clarifies that "medical evidence shows good outcomes from the use of manipulation in acute low back pain without radiculopathy (but also not necessarily any better than outcomes from other recommended treatments). If manipulation has not resulted in functional improvement in the first one or two weeks, it should be stopped and the patient reevaluated." Additionally, MTUS states "Low back: Recommended as an option. Therapeutic care- Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Elective /maintenance care - Not medically necessary. Recurrences/flare-ups - Need to reevaluate treatment success, if RTW achieved then 1-2 visits every 4-6 months." Medical documents indicate that patient has undergone approximately 24 chiropractic sessions, which would not be considered in the 'trial period' anymore. The treating provider has not demonstrated evidence of objective and measurable functional improvement

during or after the trial of therapeutic care to warrant continued treatment. As such, the request for 12 sessions of chiropractic manipulation is not medically necessary.

PHYSIOTHERAPY FOR THE LUMBAR SPINE, 3 X PER WEEK FOR 4 WEEKS, FOR A TOTAL OF 12 SESSIONS: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315, Chronic Pain Treatment Guidelines PHYSICAL THERAPY Page(s): 98-99. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES LOW BACK-LUMBAR & THORACIC.

Decision rationale: California MTUS guidelines refer to physical medicine guidelines for physical therapy and recommends as follows: "Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." Additionally, ACOEM guidelines advise against passive modalities by a therapist unless exercises are to be carried out at home by patient. ODG quantifies its recommendations with 10 visits over 8 weeks for lumbar sprains/strains and 9 visits over 8 weeks for unspecified backache/lumbago. ODG further states that a "six-visit clinical trial" of physical therapy with documented objective and subjective improvements should occur initially before additional sessions are to be warranted. Medical records indicate that the patient has had 9 sessions of physical therapy already. The treating physician did not document any objective or subjective improvement resulting from the initial therapy, which is necessary to warrant extension of additional sessions. ODG does recommend that post-surgical thoracic/lumbar physical therapy range from 16-30+ sessions over 8-16 weeks, however, there is no documentation to support that the patient is post-surgical. As such, the request for 12 sessions of physiotherapy is not medically necessary.

LIDODERM PATCH 5%, TWICE A DAY, QUANTITY: 60: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 56-57. Decision based on Non-MTUS Citation UpToDate.com

Decision rationale: Chronic Pain Medical Treatment Guidelines state "Lidoderm® is the brand name for a lidocaine patch produced by Endo Pharmaceuticals. Topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). This is not a first-line treatment and is only FDA approved for post-herpetic neuralgia. Further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. Formulations that do not involve a dermal-patch system are generally indicated as local anesthetics and anti-pruritics. For more information and references, see Topical

analgesics." Medical documents provided do not indicate that the use would be for post-herpetic neuralgia. Additionally, treatment notes do not detail the other first-line therapy used (antidepressants, gabapentin, etc) and what clinical outcomes resulted. As such, the request for Lidoderm 5% patches is not medically necessary.