

<b>Case Number:</b>	CM13-0017381		
<b>Date Assigned:</b>	11/06/2013	<b>Date of Injury:</b>	12/15/1999
<b>Decision Date:</b>	02/03/2014	<b>UR Denial Date:</b>	08/12/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/26/2013

### HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation, and is licensed to practice in Oklahoma. 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 physician 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.

### 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 patient is a 45 year old male who reported an injury on 12/15/1999. The mechanism of injury was reported by the patient that he was lifting a heavy air compressor and felt a sharp pain in his low back. The patient was diagnosed with axial low back pain, lumbar myofascial pain, lumbar radiculopathy, lumbar strain, lumbar degenerative disc disease, deconditioning, history of elevated liver function test, and history of anxiety and depression. The patient complained of back pain with radiating pain down the right lower extremity. The clinical documentation submitted for review dated 07/23/2013 stated the patient's pain level is 5/10. The patient reported the pain may decrease to a 4 at best and is in pain 90% to 100% of the time. The physical examination revealed diffused tenderness to palpation of the lumbar spinous processes, right greater than left lumbar facet paraspinal muscles, and diffused right lumbar myofascial pain including right gluteus medius, piriformis, and right greater trochanteric bursa. The patient had an antalgic gait. The lumbar range of motion in forward flexion to 30 degrees, extension was less than 5 degrees, and facet loading maneuvers were negative bilaterally. The patient had decreased range of motion of his bilateral hips with regard to internal/external rotation and, knee range of motion is reduced with extension to -10 degrees on the right and -5 degrees on the left. The patient's bilateral lower extremity is limited by pain. The patient was treated with physical therapy (more than 10 years ago), traction therapy, home exercise, hydrocodone 5/500 one tablet two times a day and gabapentin 100mg one tablet three times a day.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**12 Physical Therapy Sessions: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines (May 2009).

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

**Decision rationale:** The clinical documentation submitted for review does not meet the guideline recommendations. The clinical documentation stated the patient complained of low back pain with radiating pain to the right lower extremity. The patient had reduced range of motion and strength. However, MTUS Chronic Pain Guidelines recommend 8-10 physical therapy visits over a 4 week period. Therefore, the request exceeds the guideline recommendations. As such, the request for 12 Physical Therapy Sessions is not medically necessary and appropriate.

**1 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): 303-305.

**Decision rationale:** The patient was diagnosed with axial low back pain, lumbar myofascial pain, lumbar radiculopathy, lumbar strain, lumbar degenerative disc disease, deconditioning, history of elevated liver function test, and history of anxiety and depression. ACOEM Guidelines state that 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. No objective clinical documentation was submitted that shows the efficacy of the patient's pain medication, home exercise program or other treatments the patient has undergone as recommended by ACOEM Guidelines. As such, the request for one MRI of the lumbar spine is not medically necessary and appropriate.

**1 Lab liver function panel:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Abnormal liver chemistry- evaluation and interpretation. Medical Services Commission. Victoria (BC): British Columbia Medical Services Commission: 2011 Aug 1. 5p

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation <http://labtestsonline.org/understanding/analytes/liver-panel/tab/glance>

**Decision rationale:** The clinical documentation submitted for review does not meet the guideline recommendations. The patient was diagnosed with axial low back pain, lumbar

myofascial pain, lumbar radiculopathy, lumbar strain, lumbar degenerative disc disease, deconditioning, history of elevated liver function test, and history of anxiety and depression. The MTUS Guidelines do not address the request. Although the clinical documentation states the patient is using Hydrocodone 5/500 and Gabapentin, no clinical documentation was submitted to indicate when the last liver function panel was taken, or the results. As such, the request for one lab liver function panel is not medically necessary and appropriate

**1 prescription of Lidoderm Patches 5% (1 month supply): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines (May 2009).

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

**Decision rationale:** MTUS Chronic Pain Guidelines recommend Lidoderm 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). The clinical documentation indicates that the patient is currently using Gabapentin with no indication of failure. As such, the request for one prescription of Lidoderm patches 5% (1 month supply) is not medically necessary and appropriate.

**Lumbar X-Rays: Flexion and Extension Views: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 303.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

**Decision rationale:** 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 six weeks. The clinical documentation submitted for review does not indicate a change in the patient's condition since the injury reported in 1999; therefore, the request for lumbar x-rays flexion and extension views is not medically necessary and appropriate.