

<b>Case Number:</b>	CM14-0007308		
<b>Date Assigned:</b>	02/10/2014	<b>Date of Injury:</b>	09/17/1998
<b>Decision Date:</b>	08/04/2014	<b>UR Denial Date:</b>	12/20/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/20/2014

### 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 Physical Medicine and Rehabilitation, has a subspecialty in Interventional Spine 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:

The patient is a 53-year-old female with a date of injury of 09/11/1998. The listed diagnoses per [REDACTED] are lumbar intervertebral disks and post-surgical status. According to the progress report 11/12/2013, the patient presents with bilateral lower back pain. The pain is described as aching, throbbing, and shooting. The patient rated the pain 8/10 on the pain scale. The pain radiates down bilateral buttock, calves, foot, hip, and toes. The pain is reduced by lying down, medication, and chiropractic treatment. The patient also notes that acupuncture helps. An examination of the lumbar spine revealed decreased range of motion with flexion and extension. There are also tender areas in the lumbar region on both sides (grade 3). Palpation of the lumbar musculature demonstrates hypertonicity in that area in the lumbar region on both sides. There is +2 tenderness at the bilateral SI joint. The provider requests acupuncture treatments, chiropractic treatment x6, myofascial release x6, electronic muscle stimulation x6, electroacupuncture x6, cupping x6, infrared lamp acupuncture x6, bilateral trigger point injection to the SI joint, Tramadol, Robaxin, Gabapentin, and Flurbiprofen cream. Utilization review denied the request on 12/20/2013.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**SPINAL MANIPULATION - CHIROPRACTIC MANIPULATIVE THERAPY (CMT)**  
**(X6): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 58-59.

**Decision rationale:** This patient presents with chronic low back pain. The patient presents with continued moderate to severe pain that now radiates down to the bilateral lower extremities. The provider would like the patient to participate in spinal manipulation - chiropractic therapy 1 time a week for 6 weeks. The California MTUS recommends an optional trial of 6 visits over 2 weeks with evidence of objective functional improvement total of up to 18 visits over 6 to 8 weeks. The number of treatments received to date is unclear. On 08/14/2013 the provider reported pain relief with chiropractic treatments. In this case, the provider's statement of improvement does not substantiate functional improvement as required by California MTUS. Labor code 9792.20(e) defines functional improvement as significant improvement in ADLs or reduction in work restrictions and decreased dependence on medical treatment. Given the lack of documented functional improvement from prior chiropractic treatments, the request is not medically necessary.

**MYOFASCIAL RELEASE (X6):** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58-59.

**Decision rationale:** This patient presents with chronic low back pain. The provider is requesting myofascial release 1 time a week for 6 weeks. Myofascial release is similar to massage therapy. The California MTUS guideline under its chronic pain section has the following regarding massage therapy: "Recommended as an option as indicated below. This treatment should be an adjunct to other recommended treatment (e.g. exercise) and it should be limited to 4-6 visits in most cases." The medical file provided for review has no discussion on myofascial release. Given the patient has not tried this modality of treatment, a course of 6 session may be reasonable and within MTUS guidelines. The request is medically necessary.

**ELECTRONIC MUSCLE STIMULATION (EMS) (X6):** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular Electrical Stimulation Page(s): 121.

**Decision rationale:** This patient presents with chronic low back pain. The provider is requesting electronic muscle stimulation (EMS x6). Neuromuscular electrical stimulation (NMES devices)

(p121) are not recommended by California MTUS guidelines. NMES is used primarily as part of a rehabilitation program following stroke and there is no evidence to support its use in chronic pain. There are no intervention trials suggesting benefit from NMES for chronic pain. Therefore the request is not medically necessary.

**ELECTRO ACUPUNCTURE (X6): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** This patient presents with chronic low back pain. The provider is requesting electroacupuncture 1 time a week for 6 weeks. For acupuncture, California MTUS page 8 recommends acupuncture for pain, suffering, and restoration of function. Recommended frequency and duration is 3 to 6 treatments to produce functional improvement 1 to 2 times per year with optimal duration of 1 to 2 months. Acupuncture treatments can be extended if functional improvement is documented. Review of the reports show that the patient apparently has had acupuncture treatments in the recent past as the progress report from 11/12/2013 states that the patient benefitted from acupuncture. The record file includes one additional report from Feb. 2013 but no discussion is found regarding acupuncture. In this case, the provider's statement does not substantiate functional improvement as required by MTUS. Labor code 9792.20(e) defines functional improvement as significant improvement in ADLs or reduction in work restrictions and decreased dependence on medical treatment. Given the lack of documented functional improvement from prior acupuncture treatments, the request is not medically necessary.

**CUPPING (X6): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** This patient presents with chronic low back pain. An integral part of the acupuncture treatment is also to be used by an acupuncturist of "cupping." The provider is requesting 1 time a week for 6 weeks cupping. For acupuncture, California MTUS page 8 recommends acupuncture for pain, suffering, and restoration of function. Recommended frequency and duration is 3 to 6 treatments to produce functional improvement 1 to 2 times per year with optimal duration of 1 to 2 months. Acupuncture treatments can be extended if functional improvement is documented. Report 11/12/2013 report benefits from acupuncture. There is one prior progress report from February that provides no discussion of acupuncture. In this case, the provider's statement do not substantiate functional improvement as required by California MTUS. Labor code 9792.20(e) defines functional improvement as significant improvement in ADLs or reduction in work restrictions and decreased dependence on medical

treatment. Given the lack of documented functional improvement from prior acupuncture treatments, the request is not medically necessary.

**INFRARED LAMP ACUPUNCTURE (X6): Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** This patient presents with chronic low back pain. The provider is requesting the use of infrared lamp over the site of the needles to enhance the treatment during acupuncture treatments. For acupuncture, MTUS page 8 recommends acupuncture for pain, suffering, and restoration of function. Recommended frequency and duration is 3 to 6 treatments to produce functional improvement 1 to 2 times per year with optimal duration of 1 to 2 months. Acupuncture treatments can be extended if functional improvement is documented. Report 11/12/2013 report benefits from acupuncture. There is one prior progress report from February that provides no discussion of acupuncture. In this case, the provider's statement do not substantiate functional improvement as required by MTUS. Labor code 9792.20(e) defines functional improvement as significant improvement in ADLs or reduction in work restrictions and decreased dependence on medical treatment. Given the lack of documented functional improvement from prior acupuncture treatments, recommendations for denial.

**BILATERAL SACROILIAC TRIGGER POINT INJECTIONS: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Trigger Point Injections; Criteria For The Use Of Trigger Point Injections.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Trigger Point Injections Page(s): 122.

**Decision rationale:** This patient presents with continued low back pain. The provider is requesting bilateral sacroiliac trigger point injections. The California MTUS Guidelines page 122 under its chronic pain section has the following regarding trigger point injections, "Recommended only for myofascial pain syndrome with limited lasting value, not recommended for radicular pain." California MTUS further states that all criteria need to be met including documentation of trigger points (circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain) symptoms persist for more than 3 months, medical management therapy, radiculopathy is not present, no repeat injections unless a greater than 50% relief is obtained for 6 weeks, etc. In this case, the provider does not describe any local twitch response or taut band as required by California MTUS. Furthermore, the patient has low back pain that radiates into the buttocks and legs. California MTUS allows for trigger point injections for non-radicular pain. Therefore the request is not medically necessary.

**TRAMADOL: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol (Ultram (R)); Central Acting Analgesics.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Medications For Chronic Pain, and Opioids Page(s): 60-61 & 80-89.

**Decision rationale:** This patient presents with chronic low back pain. There is no request for tramadol in the 2 progress reports provided for review. However, report 11/12/2013 indicates current medication is "Tramadol." The medical records do not indicate dosing or quantity and there is no request for authorization. Page 78 of MTUS requires "Pain Assessment" that should include, "current pain; the least reported pain over the period since last assessment; average pain; intensity of pain after taking the opioid; how long it takes for pain relief; and how long pain relief lasts." Furthermore, "The 4 A's for ongoing monitoring" are required that include analgesia, ADL's, adverse side effects and aberrant drug-seeking behavior. The provider does not provide any pain assessment or numerical scale measuring pain, as required by California MTUS. There is no discussion on the efficacy of this medication in terms of change in work status or functional improvement. Furthermore, there is no indication of the dosing or quantity being requested. Given the lack of sufficient documentation of this medication's efficacy, the request is not medically necessary.

**ROBAXIN #60:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants - Antispasmodics.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63-64.

**Decision rationale:** This patient presents with chronic low back pain. The provider is requesting Robaxin #60. There are 2 progress reports provided for review. Report 02/05/2013 does not discuss Robaxin. Report 11/12/2013 indicates Robaxin as a current medication. The California MTUS guidelines pg 64 states "Cyclobenzaprine is recommended for a short course of therapy. Limited, mixed-evidence does not allow for a recommendation for chronic use." California MTUS does not recommend long-term use of muscle relaxant and recommends using 3-4 days for acute spasms and no more than 2-3 weeks. The provider is prescribing Robaxin for long term use. Therefore the request is not medically necessary.

**NEURONTIN/GABAPENTIN CREAM:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin) Page(s): 18-19.

**Decision rationale:** This patient presents with chronic low back pain. The provider recommends Neurontin/gabapentin for neuropathic pain. The provider does not provide quantity, dosing or duration of this medication. A review of the medical file indicates this as a current medication on report 11/12/2013, which indicates that the patient has been using this medication prior to that examination date. The California MTUS Guidelines page 18 and 19 has the following regarding Gabapentin, "Gabapentin has been shown to be effective for treatment of diabetic painful neuropathy and post-therapeutic neuralgia and has been considered a first-line treatment for neuropathic pain." This patient suffers from neuropathic pain for which use of Neurontin is indicated. However, the review of reports do not show any mention of whether or not the medication provides any pain relief. California MTUS page 60 require documentation of pain and function when medications are used for chronic pain. Given the lack of any documentation regarding the efficacy of Neurontin, the request is not medically necessary.

**FLURBIPROFEN CREAM:** Upheld

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

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

**Decision rationale:** This patient presents with chronic low back pain. The provider is requesting a flurbiprofen topical cream. The California MTUS Guidelines p 111 has the following regarding topical creams, "topical analgesics are largely experimental and used with few randomized control trials to determine efficacy or safety." California MTUS further states, "Any compounded product that contains at least one (or drug class) that is not recommended is not recommended." For Flurbiprofen, California MTUS states, "the efficacy in clinical trials for this treatment modality has been inconsistent, and most studies are small and of short duration. Topical NSAIDs had been shown in the meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis. Indications for use are osteoarthritis and tendinitis (in particular, that of the knee and elbow) or other joints that are amendable to topical treatment. In this case, the patient does not meet the indication for the topical medication as he does not present with any osteoarthritis or tendonitis symptoms. Therefore the request is not medically necessary.