

<b>Case Number:</b>	CM14-0015530		
<b>Date Assigned:</b>	02/28/2014	<b>Date of Injury:</b>	05/16/2012
<b>Decision Date:</b>	06/30/2014	<b>UR Denial Date:</b>	01/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/06/2014

### 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 & Rehabilitation and is licensed to practice in Texas. 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 injured worker is a 51 year old female injured on 05/06/12 due to an undisclosed mechanism of injury. Current diagnoses include lumbar piriformis syndrome, ruled out lumbar discopathy, lumbar disc displacement, lumbar radiculopathy, lumbar levoscoliosis, and lumbar musculoligamentous injury. The clinical documentation dated 10/01/13 indicates the injured worker presented with continued complaints of right sided low back pain with radiation into the gluteal region and right hamstring. The injured worker indicated she is awaiting scheduling for lumbar epidural steroid injection at L4-5. The injured worker reports difficulty ambulating requiring assistance with a cane for walking. Physical examination reveals motor strength 4/5 in the right lower extremity, 5/5 in the left lower extremity, deep tendon reflexes are 1+ and equal in the right lower extremity, 2+ in the left lower extremity, sensation intact to light touch, pin prick, temperature, and sensation in the bilateral lower extremities except for decreased sensation in the right L5 and right S1 dermatomes, pain with anterior flexion, posterior extension, pain with left and right lateral rotation and lateral tilt. The clinical note dated 10/16/13 indicates the injured worker presented complaining of excruciating low back pain. The documentation indicates the injured worker was recently evaluated by pain management and was recommended lumbar epidural steroid injection. Physical assessment revealed diffused tenderness in the low back as well as right buttock. The injured worker had the presence of back spasms, negative straight leg raise, calves were supple without evidence of DVT, neurovascularly intact, sensation grossly intact, and palpable pulses. Treatment plan included continue with plan for lumbar epidural steroid injections, request for chiropractic treatment 2 x a week for 4 weeks to the back, continued acupuncture 2 x a week for 4 weeks to the lower extremities. The documentation indicates that if the injured worker's pain is not improved with epidural steroid injections, chiropractic treatment, and acupuncture, the injured worker will require surgical consultation.

The initial request for chiropractic care, 1 time per week x 6 weeks, for the low back; acupuncture, 6 sessions, for the low back; physical therapy (PT), 1 x per week x 6 weeks for the low back; and medications: transdermal analgesic ointments was initially non-certified on 01/16/14.

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

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

#### **CHIROPRACTIC CARE, 1 X PER WEEK X 6 WEEKS, FOR THE LOW BACK: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, 308-310.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 59.

**Decision rationale:** As noted on page 59 of the Chronic Pain Medical Treatment Guidelines, current guidelines indicate chiropractic frequency of 1 to 2 times per week the first 2 weeks, as indicated by the severity of the condition. Treatment may continue at 1 treatment per week for the next 6 weeks with a maximum duration of 8 weeks. At week 8, patients should be reevaluated. Care beyond 8 weeks may be indicated for certain chronic pain patients in whom manipulation is helpful in improving function, decreasing pain and improving quality of life. In these cases, treatment may be continued at 1 treatment every other week until the injured worker has reached plateau and maintenance treatments have been determined. Extended durations of care beyond what is considered "maximum" may be necessary in cases of re-injury, interrupted continuity of care, exacerbation of symptoms, and in those patients with comorbidities. Such care should be re-evaluated and documented on a monthly basis. Treatment beyond 4-6 visits should be documented with objective improvement in function. The documentation indicates the injured worker has completed a total of 14 chiropractic therapy sessions; however, there were no objective findings provided that indicated functional improvement related to the chiropractic treatments. Therefore, the request for chiropractic care, 1 x per week x 6 weeks, for the low back is not medically necessary.

#### **ACUPUNCTURE, 6 SESSIONS, FOR THE LOW BACK: Upheld**

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

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

**Decision rationale:** As noted in the Acupuncture Medical Treatment Guidelines, the frequency and duration of acupuncture or acupuncture with electrical stimulation may be performed 1 to 3 times per week with an optimum duration over 1 to 2 months. Guidelines indicate that the expected time to produce functional improvement is 3 to 6 treatments. Acupuncture treatments may be extended if functional improvement is documented. The documentation indicates the injured worker has completed a total of 14 acupuncture sessions; however, there were no

objective findings provided that indicated functional improvement related to the chiropractic treatments. Therefore, the request for acupuncture, 6 sessions, for the low back is not medically necessary.

**PHYSICAL THERAPY (PT) 1 X PER WEEK X 6 WEEKS FOR THE LOW BACK:**

Upheld

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

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

**Decision rationale:** As noted on page 98 of the Chronic Pain Medical Treatment Guidelines, current guidelines recommend 10 visits over 8 weeks for the treatment of lumbar strain/sprain and allow for fading of treatment frequency (from up to 3 or more visits per week to 1 or less), plus active self-directed home physical therapy. The documentation indicates the injured worker has attended 13 physical therapy sessions. There is no documentation of exceptional factors that would support the need for therapy that exceeds guidelines either in duration of treatment or number of visits. The medical necessity of the physical therapy (pt) 1 x per week x 6 weeks for the low back is not medically necessary and appropriate.

**MEDICATIONS: TRANSDERMAL ANALGESIC OINTMENTS:** Upheld

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

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

**Decision rationale:** As noted on page 111 of the Chronic Pain Medical Treatment Guidelines, the safety and efficacy of compounded medications has not been established through rigorous clinical trials. Topical analgesics are primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. Further, CAMTUS, Food and Drug Administration, and Official Disability Guidelines require that all components of a compounded topical medication be approved for transdermal use. The components of the cream was not provided for review to determine United States Federal Drug Administration approval status. Therefore the request for transdermal analgesic ointments cannot be recommended as medically necessary.