

<b>Case Number:</b>	CM14-0132661		
<b>Date Assigned:</b>	08/22/2014	<b>Date of Injury:</b>	06/06/2014
<b>Decision Date:</b>	09/23/2014	<b>UR Denial Date:</b>	08/08/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	08/19/2014

### 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 Anesthesiology, has a subspecialty in Pain Management 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:

According to the records made available for review, this is a 28-year-old male with a 6/6/14 date of injury. At the time (7/7/14) of request for authorization for 12 Chiropractic Manipulation, MRI of the Lumbar Spine, EMG of the Right Lower Extremity, NCS of the Right Lower Extremity, Inferential Unit, Norco 205/325mg #60, and Neurontin 600mg #60. There is documentation of subjective low back pain radiating to right lower extremity with associated numbness and tingling. Objective findings are tenderness to palpation with associated muscle spasm/hypertonicity present over paraspinal musculature with the right side greater than left. The lumbosacral junction, straight leg raising test in seated and supine positives positive to the right eliciting radiating numbness and tingling to the right foot along the right L5 and S1 nerve root distribution. The lumbar flexion is 39 degrees, extension 11 degrees; right side benign 14 degrees, left side bending 13 degrees. There is sensation to pinprick and light touch in right lower extremity decreased over L5 and S1 dermatomal distribution. There is no weakness in motor testing of major muscle groups of lower extremities, and patellar and Achilles reflexes 3+. The imaging findings of the Lumbar Spine X-rays (undated) report revealed evidence of spina bifida at L5; otherwise within normal limits. The current diagnoses include lumbar spine musculoligamentous sprain/strain with attendant right lower extremity radiculitis. Treatment to date includes over-the-counter creams and stretching exercises. Medical report identifies a plan to start Norco and Neurontin. Regarding 12 Chiropractic Manipulation, the proposed 12 Chiropractic Manipulation exceeds guidelines (for an initial trial). Regarding MRI of the Lumbar Spine, there is no documentation of red flag diagnoses, failure of conservative treatment, and who are considered for surgery. Regarding EMG of the Right Lower Extremity and NCS of the Right Lower Extremity, there is no documentation of failure of 1-month of conservative therapy and that the etiology of the radicular symptoms is not explained by MRI or other diagnostic

studies. Regarding Inferential Unit, there is no documentation that the inferential unit will be used in conjunction with recommended treatments, including return to work and exercise, and limited evidence of improvement on those recommended treatments alone. Regarding Norco 205/325mg #60, there is no documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects.

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

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

### **12 Chiropractic Manipulation: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-299, Chronic Pain Treatment Guidelines Manual Therapy & manipulation Page(s): 58.

**Decision rationale:** MTUS reference to ACOEM identifies documentation of objective functional deficits and functional goals as criteria necessary to support the medical necessity of chiropractic treatment. In addition, MTUS Chronic Pain Medical Treatment Guidelines supports a trial of 6 visits, with evidence of objective functional improvement, total of up to 18 visits. Within the medical information available for review, there is documentation of a diagnosis of lumbar spine musculoligamentous sprain/strain with attendant right lower extremity radiculitis. In addition, there is documentation of objective functional deficits and functional goals. However, the proposed 12 Chiropractic Manipulation exceeds guidelines (for an initial trial). Therefore, based on guidelines and a review of the evidence, the request for 12 Chiropractic Manipulation is not medically necessary.

### **MRI of the Lumbar Spine: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-299-300, 303.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304.

**Decision rationale:** MTUS reference to ACOEM guidelines identifies documentation of red flag diagnoses where plain film radiographs are negative; objective findings that identify specific nerve compromise on the neurologic examination, failure of conservative treatment, and who are considered for surgery, as criteria necessary to support the medical necessity of MRI. Within the medical information available for review, there is documentation of a diagnosis of lumbar spine musculoligamentous sprain/strain with attendant right lower extremity radiculitis. In addition, there is documentation that plain film radiographs are negative. Furthermore, given

documentation of subjective (low back pain radiating to right lower extremity with associated numbness and tingling) and objective (sensation to pinprick and light touch in right lower extremity decreased over L5 and S1 dermatomal distribution and Achilles reflexes 3+) findings, there is documentation of objective findings that identify specific nerve compromise on the neurologic examination. However, there is no documentation of red flag diagnoses, failure of conservative treatment, and who are considered for surgery. Therefore, based on guidelines and a review of the evidence, the request for MRI of the Lumbar Spine is not medically necessary.

**EMG of the Right Lower Extremity: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back-Lumbar & Thoracic (Acute & Chronic).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Electrodiagnostic studies.

**Decision rationale:** MTUS reference to ACOEM guidelines identifies documentation of focal neurologic dysfunction in patients with low back symptoms lasting more than three to four weeks, as criteria necessary to support the medical necessity of electrodiagnostic studies. ODG identifies documentation of evidence of radiculopathy after 1-month of conservative therapy, as criteria necessary to support the medical necessity of electrodiagnostic studies. Within the medical information available for review, there is documentation of a diagnosis of lumbar spine musculoligamentous sprain/strain with attendant right lower extremity radiculitis. In addition, given documentation of subjective (low back pain radiating to right lower extremity with associated numbness and tingling) and objective (sensation to pinprick and light touch in right lower extremity decreased over L5 and S1 dermatomal distribution and Achilles reflexes 3+) findings, there is documentation of radiculopathy. However, there is no documentation of failure of 1-month of conservative therapy. In addition, given documentation of a subsequent request for a MRI of the Lumbar Spine at the time of the requested EMG/NCV, there is no documentation that the etiology of the radicular symptoms is not explained by MRI or other diagnostic studies. Therefore, based on guidelines and a review of the evidence, the request for EMG of the Right Lower Extremity is not medically necessary.

**NCS of the Right Lower Extremity: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back-Lumbar & Thoracic (Acute & Chronic).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Electrodiagnostic studies.

**Decision rationale:** MTUS reference to ACOEM guidelines identifies documentation of focal neurologic dysfunction in patients with low back symptoms lasting more than three to four weeks, as criteria necessary to support the medical necessity of electrodiagnostic studies. ODG identifies documentation of evidence of radiculopathy after 1-month of conservative therapy, as criteria necessary to support the medical necessity of electrodiagnostic studies. Within the medical information available for review, there is documentation of a diagnosis of lumbar spine musculoligamentous sprain/strain with attendant right lower extremity radiculitis. In addition, given documentation of subjective (low back pain radiating to right lower extremity with associated numbness and tingling) and objective (sensation to pinprick and light touch in right lower extremity decreased over L5 and S1 dermatomal distribution and Achilles reflexes 3+) findings, there is documentation of radiculopathy. However, there is no documentation of failure of 1-month of conservative therapy. In addition, given documentation of a subsequent request for a MRI of the Lumbar Spine at the time of the requested EMG/NCV, there is no documentation that the etiology of the radicular symptoms is not explained by MRI or other diagnostic studies. Therefore, based on guidelines and a review of the evidence, the request for NCS of the Right Lower Extremity is not medically necessary.

**Inferential Unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 173, Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies that interferential current stimulation is not recommended as an isolated intervention and that there is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. Within the medical information available for review, there is documentation of a diagnosis of lumbar spine musculoligamentous sprain/strain with attendant right lower extremity radiculitis. However, there is no documentation that the Inferential unit will be used in conjunction with recommended treatments, including return to work and exercise, and limited evidence of improvement on those recommended treatments alone. Therefore, based on guidelines and a review of the evidence, the request for inferential unit is not medically necessary.

**Norco 205/325mg #60:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-80.

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines necessitate documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; and there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects, as criteria necessary to support the medical necessity of opioids. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of a diagnosis of lumbar spine musculoligamentous sprain/strain with attendant right lower extremity radiculitis. In addition, there is documentation of a plan to start Norco. However, there is no documentation that the prescriptions are from a single practitioner and are taken as directed; the lowest possible dose is being prescribed; there will be ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects. Therefore, based on guidelines and a review of the evidence, the request for Norco 205/325mg #60 is not medically necessary.

**Neurontin 600mg #60:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Antiepilepsy Drugs (AEDs).

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

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of neuropathic pain, as criteria necessary to support the medical necessity of Neurontin (gabapentin). MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of a diagnosis of lumbar spine musculoligamentous sprain/strain with attendant right lower extremity radiculitis. In addition, there is documentation of a plan to start Neurontin. Furthermore, there is documentation of neuropathic pain. Therefore, based on guidelines and a review of the evidence, the request for Neurontin 600mg #60 is medically necessary.