

<b>Case Number:</b>	CM14-0054697		
<b>Date Assigned:</b>	07/28/2014	<b>Date of Injury:</b>	06/20/2011
<b>Decision Date:</b>	09/09/2014	<b>UR Denial Date:</b>	04/17/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/24/2014

### 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 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 42 year old female who sustained an injury on 06/20/11. No specific mechanism of injury was noted. Prior treatment for the injured worker has included chiropractic therapy visits for continuing complaints of low back pain. The injured worker had been previously recommended for epidural steroid injections. No surgical history was identified. The injured worker had been treated with multiple medications to include Norco and Lidoderm patches. The clinical report from 03/25/14 noted ongoing complaints of low back pain radiating to the lower extremities with associated numbness and tingling in the left upper back region. The injured worker's physical examination noted ongoing loss of range of motion in the lumbar spine with decreased sensation to touch in the left lower extremity from the knee to the foot. The injured worker also exhibited decreased strength on dorsal and plantar flexion. The injured worker was seen for a qualified medical evaluation on 04/08/14 and was noted to have tenderness to palpation in multiple areas including the left hip region as well as the low back. There was noted tenderness over the left sacroiliac joint. The injured worker was recommended for craniosacral therapy for 7 sessions as well as Norco 5/325 mg #90, a left lateral femoral cutaneous nerve block, lumbar epidural steroid injections, MRI study of the left hip and additional cognitive behavioral therapy for 6 sessions. All of this was denied by utilization review on 04/17/14.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Craniosacral Therapy x7: Upheld**

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

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

**Decision rationale:** In regards to the request for craniosacral therapy x 7, the clinical documentation submitted for review would not support the requested service. There was no specific documentation regarding functional benefits expected with this therapy. No clear goals were set in the clinical documentation provided for review, and it is unclear how this therapy would have reasonably provided benefit to the injured worker for an injury over 3 years old. Therefore, the request for craniosacral therapy x7 is not medically necessary and appropriate.

**Norco 5/325mg #90:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Criteria for Use Page(s): 98-99.

**Decision rationale:** The patient has been utilizing this medication over extended period of time. Per current evidence based guidelines, the use of a short acting narcotic such as Norco can be considered an option in the treatment of moderate to severe musculoskeletal pain. The benefits obtained from short acting narcotics diminishes over time and guideline recommend that there be ongoing indications of functional benefit and pain reduction to support continuing use of this medication. Overall, there is insufficient evidence in the clinical literature that long term use of narcotic medications results in any functional improvement. The clinical documentation provided for review did not identify any particular functional improvement obtained with the ongoing use of Norco. No specific pain improvement was attributed to the use of this medication. The clinical documentation also did not include any compliance measures such as toxicology testing or long term opiate risk assessments (COMM/SOAPP) to determine risk stratification for this claimant. Therefore, the request for Norco 5/325mg #90 is not medically necessary and appropriate.

**Left Lateral femoral cutaneous nerve block:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines hip & pelvis.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: Current Medical Diagnosis and Treatment, 2012. Goroll A.H. Primary Care Medicine, 7th ed. ISBN/ISSN: 9781451151497.

**Decision rationale:** In regards to the request for left lateral femoral cutaneous nerve block, the clinical documentation submitted for review did not identify any specific findings consistent with neuropathic pain in a left lateral femoral distribution. The injured worker's physical examination findings were largely myofascial in nature. Given the absence of any clear evidence regarding neuropathic symptoms from the left lateral femoral cutaneous nerve, this request would not be considered medically appropriate.

**Lumbar Epidural Steroid Injection:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46.

**Decision rationale:** In regards to the request for lumbar epidural steroid injection, no imaging studies of the lumbar spine were available for review identifying any significant nerve root involvement at any lumbar level. The injured worker's physical examination findings were not clearly indicative of a lumbar radiculopathy as recommended by guidelines. Therefore, this request would not be considered medically appropriate per guidelines.

**MRI(Magnetic Resonance Imaging) of the left hip:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Hip & Pelvis.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip & Pelvis, MRI.

**Decision rationale:** There is no indication of any recent trauma to the left hip, or any plain film radiograph studies of the left hip identifying nondiagnostic features. Per guidelines, there should be evidence regarding potential instability or other trauma to the hip to warrant advanced imaging studies. As this was not clearly evident in the clinical documentation, the request for MRI (Magnetic Resonance Imaging) of the left hip is not medically necessary and appropriate.

**Additional CBT)Cognitive Behavior Therapy x 6:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 23. Decision based on Non-MTUS Citation Official Disability Guidelines-Cognitive Behavior Therapy Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Psychological treatment Page(s): 101-102.

**Decision rationale:** There were no prior cognitive behavioral therapy summary reports establishing efficacy of this type of treatment. It is unclear what further psychological symptoms remain that would reasonably require additional treatment at this point in time. Therefore, the request for additional CBT) Cognitive Behavior Therapy x 6 is not medically necessary and appropriate.