

<b>Case Number:</b>	CM14-0097936		
<b>Date Assigned:</b>	09/23/2014	<b>Date of Injury:</b>	01/14/2014
<b>Decision Date:</b>	12/12/2014	<b>UR Denial Date:</b>	05/28/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/25/2014

### 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 Internal Medicine, has a subspecialty in Nephrology 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:

Patient is a 51-year-old female who has submitted a claim for whiplash mechanism injury with lumbar sprain/strain and probable lumbar discopathy associated with an industrial injury date of 1/14/2014. Medical records from 2014 were reviewed. Patient complained of low back pain aggravated by bending, sitting, and walking. Patient denied radiation of symptoms to lower extremities. Physical examination of the lumbar spine showed moderate spasm and tenderness. Range of motion was minimally restricted. Weakness of trunk flexors and extensors was noted. Straight leg raise test was positive at 60 degrees. Weakness was noted at ankle plantar flexors and dorsiflexors. MRI of the lumbar spine, dated 2/24/2014, revealed a 3-mm posterior central disk protrusion at L5 to S1 which indent the anterior thecal sac but did not result in significant spinal stenosis. Treatment to date has included 12 sessions of physical therapy, chiropractic care, trigger point and ligament injections, and medications. Patient reported that previous physical therapy sessions provided no relief of symptoms. Utilization review from 5/27/2014 denied the request for physical therapy for the lumbar spine 2 x 3 because previous sessions were not documented in terms of specific treatment modalities given and functional outcomes; denied TENS unit because there was no documentation concerning previous benefits with its use and it was unclear if the device would be used as an adjunct to physical therapy; denied lumbar brace because it was only recommended following spinal fusion procedures or with documented instability; and denied Flurbiprofen and Ketoprofen topical cream because of limited published studies concerning its efficacy and safety.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy for the lumbar spine (2 x 3): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back (05/12/2014)

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

**Decision rationale:** As stated on pages 98-99 of the California MTUS Chronic Pain Medical Treatment Guidelines, physical medicine is recommended and that given frequency should be tapered and transition into a self-directed home program. Guidelines recommend 9 to 10 visits over 8 for myalgia and myositis, and 8 to 10 visits over 4 weeks for neuralgia, neuritis, and radiculitis. In this case, patient previously completed a course of physical therapy totaling 12 sessions without noted improvement. Given that previous visits failed to provide significant pain improvement and functional gains, there was no compelling rationale to provide extension of therapy services. Moreover, it was unclear why patient was still not instructed to perform self-directed exercises to address residual deficits. Therefore, the request for physical therapy for the lumbar spine 2 x 3 is not medically necessary.

**TENS unit: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 116.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS in Chronic Pain Page(s): 114,116.

**Decision rationale:** As stated on page 114 of CA MTUS Chronic Pain Medical Treatment Guidelines, TENS units are not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration. In this case, patient complained of persistent low back pain despite physical therapy and chiropractic care. A trial of TENS unit may be warranted to address present impairments and activity limitations. However, there was no discussion concerning an adjunct exercise program; solitary use of TENS unit was not guideline recommended. Moreover, the present request as submitted failed to specify duration of TENS unit use, as well as if the device was for rental or purchase. Therefore, the request for TENS unit is not medically necessary.

**Lumbar brace: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back (05/12/2014)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Lumbar Section, Lumbar Support

**Decision rationale:** As stated on CA MTUS ACOEM Low Back Chapter, lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. The Official Disability Guidelines recommend lumbar supports as an option for compression fractures and specific treatment for spondylolisthesis and documented instability. In this case, patient complains of persistent low back pain despite physical therapy and chiropractic care since the injury date of 1/14/2014. Patient denies radiation of symptoms to bilateral lower extremities. However, the request for a back brace as part of the conservative treatment regimen is outside the initial acute phase of injury and not supported by the guidelines. Moreover, patient has no compression fracture, lumbar instability, and spondylolisthesis to warrant its use. Therefore, the request for back brace is not medically necessary.

**Flurbiprofen & Ketoprofen topical cream:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111-112. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter (05/15/2014)

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

**Decision rationale:** As stated on pages 111-113 of the California MTUS Chronic Pain Medical Treatment Guidelines, topical analgesics are largely experimental in use with few randomized controlled trials to determine safety or efficacy. Topical NSAIDs formulation is only supported for Diclofenac in the California MTUS. In addition, there is little to no research as for the use of Flurbiprofen in compounded products. Ketoprofen is not recommended for topical usage as there is a high incidence of photo contact dermatitis. In this case, topical cream is prescribed as treatment to low back pain. Patient has no current oral medication. However, the prescribed medication contains Flurbiprofen and Ketoprofen, which are not recommended for topical use. Guidelines state that any compounded product that contains a drug class, which is not recommended, is not recommended. There is likewise no evidence the patient has intolerance to or failure of oral medications to warrant such treatment. Therefore, the request for Flurbiprofen and ketoprofen topical cream is not medically necessary.