

Case Number:	CM14-0156108		
Date Assigned:	11/13/2014	Date of Injury:	08/30/2012
Decision Date:	01/09/2015	UR Denial Date:	08/25/2014
Priority:	Standard	Application Received:	09/23/2014

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 Family Medicine 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 51 year old male with an injury date of 08/30/12. Based on the 08/19/14 progress report provided by treating physician, the patient complains of low back pain rated 5/10 that radiates to the left leg with tingling and numbness. Physical examination to the lumbar spine revealed tenderness to palpation to the paralumbar muscles. Range of motion was limited. Physical exam dated 05/08/14 revealed straight leg raise positive bilaterally and weakness noted to the left lower extremity. Per progress report dated 05/08/14, medications decrease pain from 5-6/10 to 3/10. Physicians report dated 08/19/14 states that "patient has benefited to a degree with current medications and requires continuation for the maintenance of activities of daily living." Physical therapy and acupuncture provided minimal relief. Patient reports heartburn, and developed secondary treatable sequel of gastric side effects from primary injury. Per progress report dated 05/08/14, Omeprazole is prescribed for gastric protection and Tramadol for pain. Tramadol, Omeprazole and Diclofenac were prescribed in the physicians report dated 03/07/14, and 04/10/14. Pantoprazole and Tramadol were prescribed on 08/19/14, per physicians report. Urine drug screen done on 04/10/14, 05/08/14 and 08/19/14 to monitor the patient's medication compliance. Per QME report dated 06/21/14, patient had MRI of the Lumbar spine on 08/06/12. Patient is temporarily totally disabled. MRI of the Lumbar Spine 08/06/12 - left paracentral disc protrusion extending to the left lateral recess at L4-5 with probable compromise of left descending nerve roots. Diagnosis as of 05/08/14 include lumbar spine herniated nucleus pulposus, hypertension, gouty arthritis, gastritis. Diagnosis 06/21/14 (QME) is chronic non-radicular lumbar spine pain. Diagnosis as of 08/19/14 is lumbar disc protrusion. The utilization review determination being challenged is dated 08/25/14. Treatment reports were provided from 03/04/14 - 08/19/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic visits three times a week for four weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Manipulation

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Low back Page(s): 58-59.

Decision rationale: The patient presents with low back pain rated 5/10 that radiates to the left leg with tingling and numbness. Patient's diagnosis on 05/08/14 included lumbar spine herniated nucleus pulposus and gastritis. Per QME report dated 06/21/14, diagnosis was chronic non-radicular spine pain, and on 08/19/14 it was lumbar disc protrusion. Physicians report dated 08/19/14 states that physical therapy and acupuncture provided minimal relief. MTUS Guidelines pages 58-59 states, "Low back: Recommended as an option. Therapeutic care - Trial of 6 visits over 2 weeks, with evidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Per Request for authorization form dated 08/21/14, the request is made for the diagnosis of lumbar disc protrusion. Physicians report dated 08/19/14 states that physical therapy and acupuncture provided minimal relief. Patient still presents with low back pain. Medical records do not show patient has had chiropractic in the past, and a trial of chiropractic would be reasonable. However, the requested 12 visits exceed what is allowed by MTUS. Therefore the request is not medically necessary.

Urinalysis for toxicology: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) Chapter, Urine drug testing (UDT)

Decision rationale: The patient presents with low back pain rated 5/10 that radiates to the left leg with tingling and numbness. The request is for URINALYSIS FOR TOXICOLOGY. Patient's diagnosis on 05/08/14 included lumbar spine herniated nucleus pulposus and gastritis. Per QME report dated 06/21/14, diagnosis was chronic non-radicular spine pain, and on 08/19/14 it was lumbar disc protrusion. Tramadol was prescribed in treater reports dated 03/07/14 and 08/19/14. While MTUS Guidelines do not specifically address how frequent UDS should be obtained for various risks of opiate users, ODG Guidelines provide clearer recommendation. ODG has the following criteria regarding Urine Drug Screen: "Patients at "low risk" of addiction/aberrant behavior should be tested within six months of initiation of therapy and on a yearly basis thereafter. There is no reason to perform confirmatory testing unless the test is inappropriate or there are unexpected results. If required, confirmatory testing should be for the

questioned drugs only. Patients at "moderate risk" for addiction/aberrant behavior are recommended for point-of-contact screening 2 to 3 times a year with confirmatory testing for inappropriate or unexplained results. Patients at "high risk" of adverse outcomes may require testing as often as once per month. This category generally includes individuals with active substance abuse disorders."Based on progress reports, urine drug screen was done on 04/10/14, 05/08/14 and 08/19/14 to monitor the patient's medication compliance. There is no discussion regarding the results. Treater has not documented that patient is at "high risk" of adverse outcomes, or has active substance abuse disorder. Though ODG and MTUS do support periodic urine toxicology for opiate management, in this case, it appears that urine drug screens are used excessively. Recommendation is for denial.

IF unit: 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), Interferential current stimulation

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

Decision rationale: The patient presents with low back pain rated 5/10 that radiates to the left leg with tingling and numbness. Patient's diagnosis on 05/08/14 included lumbar spine herniated nucleus pulposus and gastritis. Per QME report dated 06/21/14, diagnosis was chronic non-radicular spine pain, and on 08/19/14 it was lumbar disc protrusion. Physicians report dated 08/19/14 states that physical therapy and acupuncture provided minimal relief. Medications include Pantoprazole and Tramadol per physicians report dated 08/19/14. MTUS pages 118 to 120 states that Interferential Current Stimulation (ICS) are not recommended as an isolated intervention. MTUS further states, "While not recommended as an isolated intervention, Patient selection criteria if Interferential stimulation is to be used anyway." It may be appropriate if pain is not effectively controlled due to diminished effectiveness or side effects of medication; history of substance abuse, significant pain due to postoperative conditions; or the patient is unresponsive to conservative measures. A one month trial may be appropriate if the above criteria are met. Per Request for authorization form dated 08/21/14, the request is made for the diagnosis of lumbar disc protrusion. Physician has not discussed reason for the request, nor indicated whether IF unit is for rental or purchase. There is no evidence that pain is not effectively controlled by medications as required by MTUS. Per progress report dated 05/08/14, medications decrease pain from 5-6/10 to 3/10. Review of medical records do not document that patient has trialed TENS. The request does not meet guideline criteria. Therefore the request is not medically necessary.

Motorized cold therapy unit: 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), Shoulder

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic) Chapter, Cold/heat packs

Decision rationale: The patient presents with low back pain rated 5/10 that radiates to the left leg with tingling and numbness. Patient's diagnosis on 05/08/14 included lumbar spine herniated nucleus pulposus and gastritis. Per QME report dated 06/21/14, diagnosis was chronic non-radicular spine pain, and on 08/19/14 it was lumbar disc protrusion. The physicians report dated 08/19/14 states that physical therapy and acupuncture provided minimal relief. Medications include Pantoprazole and Tramadol per physicians report dated 08/19/14. The MTUS and ACOEM Guidelines are silent with regards to this request. However, ODG Guidelines recommend at-home, local applications of cold pack in the first few days of acute complaints; thereafter, application of heat packs. ODG further states that mechanical circulating units with pumps have not been proven to be more effective than passive hot/cold therapy. Per Request for authorization form dated 08/21/14, the request is made for the diagnosis of lumbar disc protrusion. The physician has not discussed reason for the request. Patient presents with low back pain, however ODG guidelines do not support the use of mechanical circulating units for the treatment of generalized lumbar pain. At-home application of hot/cold should be sufficient. Therefore the request is not medically necessary.

Theramine #90: 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), 7th Edition, 2010; Pain (chronic); Theramine Capsules (medical food)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) Chapter, Theramine®

Decision rationale: The patient presents with low back pain rated 5/10 that radiates to the left leg with tingling and numbness. Patient's diagnosis on 05/08/14 included lumbar spine herniated nucleus pulposus and gastritis. Per QME report dated 06/21/14, diagnosis was chronic non-radicular spine pain, and on 08/19/14 it was lumbar disc protrusion. The physicians report dated 08/19/14 states that physical therapy and acupuncture provided minimal relief. Medications include Pantoprazole and Tramadol per physician report dated 08/19/14. ODG guidelines Pain Chapter state the following about Theramine, "Not recommended for the treatment of chronic pain. Theramine is a medical food from ██████████, that is a proprietary blend of gamma-aminobutyric acid [GABA] and choline bitartrate, L-arginine, and L-serine." Per Request for authorization form dated 08/21/14, the request is made for the diagnosis of lumbar disc protrusion. The physicians has not provided reason for the request, nor discussed how this medical food will be used. Based on ODG, Theramine is not recommended for the treatment of chronic pain. Due to lack of support by guidelines, therefore the request is not medically necessary. Per Request for authorization form dated 08/21/14, the request is made for the diagnosis of lumbar disc protrusion. Treater has not provided reason for the request, nor discussed how this medical food will be used. Based on

ODG, Theramine is not recommended for the treatment of chronic pain. Due to lack of support by guidelines, recommendation is for denial.

Sentra #60: 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), 7th Edition, 2009; On-line Medical Chapter for Pain

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Medical Food

Decision rationale: The patient presents with low back pain rated 5/10 that radiates to the left leg with tingling and numbness. The request is for SENTRA #60. Patient's diagnosis on 05/08/14 included lumbar spine herniated nucleus pulposus and gastritis. Per QME report dated 06/21/14, diagnosis was chronic non-radicular spine pain, and on 08/19/14 it was lumbar disc protrusion. The physician report dated 08/19/14 states that physical therapy and acupuncture provided minimal relief. Medications include Pantoprazole and Tramadol per physicians report dated 08/19/14. Per www.ptlcentral.com, Sentra PM are capsules by oral administration, especially formulated prescription only medical food, consisting of a proprietary formulation of amino acids and polyphenol ingredients in specific proportions, for the dietary management of the altered metabolic processes of sleep disorders associated with depression (www.ptlcentral.com). ODG, Pain Chapter, Medical Food states: "medical food: intended for a specific dietary management of a disease or condition for which distinctive nutritional requirements are established by medical evaluation. To be considered, the product must meet the following criteria: 1. The product must be a food for oral or tube feeding. 2. The product must be labeled for dietary management of a specific medical disorder. 3. The product must be used under medical supervision." Per Request for authorization form dated 08/21/14, the request is made for the diagnosis of lumbar disc protrusion. The physician has not discussed reason for the request. Sentra PM does not meet ODG criteria for medical foods, and currently there are no guidelines discussing this product. Therefore the request is not medically necessary. ODG, Pain Chapter, Medical Food states: "medical food: intended for a specific dietary management of a disease or condition for which distinctive nutritional requirements are established by medical evaluation. To be considered, the product must meet the following criteria: 1. The product must be a food for oral or tube feeding. 2. The product must be labeled for dietary management of a specific medical disorder. 3. The product must be used under medical supervision." Per Request for authorization form dated 08/21/14, the request is made for the diagnosis of lumbar disc protrusion. Treater has not discussed reason for the request. Sentra PM does not meet ODG criteria for medical foods, and currently there are no guidelines discussing this product. Recommendation is for denial.

Topical cream Flurbiprofen/Capsaicin/Camphor 120gm (10/0.025%/2%/1%): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines, (ODG), Pain, Topical Analgesics

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical creams Page(s): 111.

Decision rationale: The patient presents with low back pain rated 5/10 that radiates to the left leg with tingling and numbness. Patient's diagnosis on 05/08/14 included lumbar spine herniated nucleus pulposus and gastritis. Per QME report dated 06/21/14, diagnosis was chronic non-radicular spine pain, and on 08/19/14 it was lumbar disc protrusion. The physicians report dated 08/19/14 states that physical therapy and acupuncture provided minimal relief. Medications include Pantoprazole and Tramadol per physicians report dated 08/19/14. MTUS has the following regarding topical creams (p111, chronic pain section): "Topical Analgesics: Non-steroidal anti-inflammatory agents (NSAIDs): The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Topical NSAIDs have been shown in meta-analysis to be superior to placebo during the first 2 weeks of treatment for osteoarthritis, but either not afterward, or with a diminishing effect over another 2-week period." Per Request for authorization form dated 08/21/14, the request is made for the diagnosis of lumbar disc protrusion. The physician has not discussed reason for the request. Review of reports does not show documentation that patient presents with diagnosis of osteoarthritis. Requested cream is not in line with MTUS indication. Therefore the request is not medically necessary.

Topical cream Ketoprofen/ Cyclobenzaprine/Lidocaine 120gm (10%/3%/5%): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics. Decision based on Non-MTUS Citation Official Disability Guidelines, (ODG), Pain, Topical Analgesics

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines topical creams Page(s): 111.

Decision rationale: The patient presents with low back pain rated 5/10 that radiates to the left leg with tingling and numbness. Patient's diagnosis on 05/08/14 included lumbar spine herniated nucleus pulposus and gastritis. Per QME report dated 06/21/14, diagnosis was chronic non-radicular spine pain, and on 08/19/14 it was lumbar disc protrusion. Physicians report dated 08/19/14 states that physical therapy and acupuncture provided minimal relief. Medications include Pantoprazole and Tramadol per physician report dated 08/19/14. The MTUS has the following regarding topical creams (p111, chronic pain section): "Topical Analgesics: Recommended as an option as indicated below. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Non-steroidal anti-inflammatory agents (NSAIDs): The efficacy in clinical trials for this treatment modality has been inconsistent and most studies are small and of short duration. Gabapentin: Not recommended. Baclofen: Not recommended. Other muscle relaxants: There is no evidence for use of any other muscle relaxant as a topical product. Topical lidocaine, in the formulation of a

dermal patch (Lidoderm) has been designated for orphan status by the FDA for neuropathic pain. Lidoderm is also used off-label for diabetic neuropathy. No other commercially approved topical formulations of lidocaine (whether creams, lotions or gels) are indicated for neuropathic pain." Per Request for authorization form dated 08/21/14, the request is made for the diagnosis of lumbar disc protrusion. The physician has not discussed reason for the request. MTUS page 111 states that if one of the compounded topical products is not recommended, then the entire product is not. In this case, the requested topical compound contains Cyclobenzaprine and Lidocaine, which are not supported for topical use in lotion form per MTUS. Therefore the request is not medically necessary.

Protonix (Pantoprazole) 20mg #60: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs. Decision based on Non-MTUS Citation www.nlm.nih.gov

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs, GI symptoms and cardiovascular risk Page(s): 69.

Decision rationale: The patient presents with low back pain rated 5/10 that radiates to the left leg with tingling and numbness. Patient's diagnosis on 05/08/14 included lumbar spine herniated nucleus pulposus and gastritis. Patient's diagnosis on 05/08/14 included lumbar spine herniated nucleus pulposus and gastritis. Per QME report dated 06/21/14, diagnosis was chronic non-radicular spine pain, and on 08/19/14 it was lumbar disc protrusion. The physicians report dated 08/19/14 states that physical therapy and acupuncture provided minimal relief. Medications include Pantoprazole and Tramadol per physicians report dated 08/19/14. MTUS page 69 states "NSAIDs, GI symptoms and cardiovascular risk,: Treatment of dyspepsia secondary to NSAID therapy: Stop the NSAID, switch to a different NSAID, or consider H2-receptor antagonists or a PPI." Regarding Protonix, or a proton pump inhibitor, MTUS allows it for prophylactic use along with oral NSAIDs when appropriate GI risk is present such as age greater 65; concurrent use of anticoagulants, ASA or high dose of NSAIDs; history of PUD, gastritis, etc. This medication also can be used for GI issues such as GERD, PUD or gastritis. FDA indications <http://www.drugs.com/pro/protonix.html>, are present "Protonix- Pantoprazole, a PPI, Gastroesophageal Reflux Disease Associated with a History of Erosive Esophagitis. Protonix I.V. for Injection is indicated for short-term treatment (7 to 10 days) of adult patients with gastroesophageal reflux disease (GERD) and a history of erosive esophagitis." Per Request for authorization form dated 08/21/14, the request is made for the diagnosis of lumbar disc protrusion. The physician has not discussed reason for the request. Per progress report dated 03/07/14, Omeprazole is prescribed for gastric protection. Diclofenac was last prescribed in progress report dated 04/10/14. The physician states "patient reports heartburn, and developed secondary treatable sequel of gastric side effects from primary injury," per progress report dated 08/19/14, at which point Pantoprazole was initiated. Patient's history of gastric issues has been documented, NSAID stopped, and Omeprazole was replaced with Protonix. Per progress report dated 05/08/14, patient has a diagnosis of gastritis. The request is in line with MTUS indications. Therefore the request is medically necessary.

Tramadol 50mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Tramadol. Decision based on Non-MTUS Citation Official Disability Guidelines, 7th Edition, 2001; Tramadol

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 88-89, 78.

Decision rationale: The patient presents with low back pain rated 5/10 that radiates to the left leg with tingling and numbness. Patient's diagnosis on 05/08/14 included lumbar spine herniated nucleus pulposus and gastritis. Patient's diagnosis on 05/08/14 included lumbar spine herniated nucleus pulposus and gastritis. Per QME report dated 06/21/14, diagnosis was chronic non-radicular spine pain, and on 08/19/14 it was lumbar disc protrusion. The physicians report dated 08/19/14 states that physical therapy and acupuncture provided minimal relief. Per progress report dated 05/08/14, medications decrease pain from 5-6/10 to 3/10. Urine drug screen done on 04/10/14, 05/08/14 and 08/19/14 to monitor the patient's medication compliance. Tramadol was prescribed for pain in physician report dated 03/07/14 and 08/19/14. Patient is temporarily totally disabled. MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. Per Request for Authorization form dated 08/21/14, the request is made for the diagnosis of lumbar disc protrusion. Progress report dated 05/08/14 states Tramadol is prescribed for pain. Progress report dated 08/19/14 states that "patient has benefited to a degree with current medications and requires continuation for the maintenance of activities of daily living." In this case, the physician has not stated how Tramadol significantly improves his activities of daily living. UDS's were done, however documentation of results was not provided. The four A's are not specifically addressed including discussions regarding aberrant drug behavior and adverse effects, etc. Given the lack of documentation as required by MTUS, the request is not medically necessary.

X-ray of the lumbar spine: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic) Chapter, Radiography (x-rays)

Decision rationale: The patient presents with low back pain rated 5/10 that radiates to the left leg with tingling and numbness. Patient's diagnosis on 05/08/14 included lumbar spine herniated nucleus pulposus and gastritis. Patient's diagnosis on 05/08/14 included lumbar spine herniated nucleus pulposus and gastritis. Per QME report dated 06/21/14, diagnosis was chronic non-radicular spine pain, and on 08/19/14 it was lumbar disc protrusion. The physicians report dated

08/19/14 states that physical therapy and acupuncture provided minimal relief. Medications include Pantoprazole and Tramadol per physicians report dated 08/19/14. Urine drug screen done on 04/10/14, 05/08/14 and 08/19/14 to monitor the patient's medication compliance. Per QME report dated 06/21/14, patient had MRI of the Lumbar spine done on 08/06/12. Patient is temporarily totally disabled. ODG-TWC, Low Back - Lumbar & Thoracic (Acute & Chronic) Chapter states: "Radiography (x-rays): Not recommend routine x-rays in the absence of red flags. Indications for imaging -- Plain X-rays: - Lumbar spine trauma (a serious bodily injury): pain, tenderness - Lumbar spine trauma: trauma, neurological deficit - Lumbar spine trauma: seat belt (chance) fracture- Uncomplicated low back pain, trauma, steroids, osteoporosis, over 70 - Uncomplicated low back pain, suspicion of cancer, infection - Myelopathy (neurological deficit related to the spinal cord), traumatic - Myelopathy, painful - Myelopathy, sudden onset- Myelopathy, infectious disease patient- Myelopathy, oncology patient - Post-surgery: evaluate status of fusion" Per Request for Authorization form dated 08/21/14, the request is made for the diagnosis of lumbar disc protrusion. The physician has not discussed reason for the request. Review of medical records do not document that patient has lumbar spine trauma with neurological deficits, is postoperative, or presents with red flags such as fracture, suspicion of cancer or infection. Therefore the request is not medically necessary.

MRI of the lumbar spine: 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, Radiography and MRIs

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic) Chapter, MRIs (magnetic resonance imaging)

Decision rationale: The patient presents with low back pain rated 5/10 that radiates to the left leg with tingling and numbness. Patient's diagnosis on 05/08/14 included lumbar spine herniated nucleus pulposus and gastritis. Patient's diagnosis on 05/08/14 included lumbar spine herniated nucleus pulposus and gastritis. Per QME report dated 06/21/14, diagnosis was chronic non- radicular spine pain, and on 08/19/14 it was lumbar disc protrusion. The physician report dated 08/19/14 states that physical therapy and acupuncture provided minimal relief. Medications include Pantoprazole and Tramadol per physicians report dated 08/19/14. Regarding MRI of L- spine ACOEM guidelines, Chapter 12, page 303 states: "Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option." For uncomplicated low back pain, ODG guidelines require at least one month of conservative therapy and sooner if severe or progressive neurologic deficit is present for an MRI. ODG supports an MRI for prior lumbar surgery as well. Per Request for Authorization form dated 08/21/14, the request is made for the diagnosis of lumbar disc protrusion. The physician has not discussed reason for the request. Per QME report dated 06/21/14, patient had MRI of the Lumbar spine on 08/06/12, which revealed left paracentral disc protrusion extending to the left lateral recess at L4-5 with probable compromise of left descending nerve roots. For an updated

or repeat MRI, the patient must be post-operative or present with a new injury, red flags such as infection, tumor, fracture or neurologic progression. This patient does not present with any of these therefore request is not medically necessary.

Functional capacity evaluation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM, Chapter 7 pages 137-138 and the Official Disability Guidelines (ODG), Chronic Pain and Low Back sections

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) chapter 7, page 137-139, FUNCTIONAL CAPACITY EVALUATION

Decision rationale: The patient presents with low back pain rated 5/10 that radiates to the left leg with tingling and numbness. Patient's diagnosis on 05/08/14 included lumbar spine herniated nucleus pulposus and gastritis. Patient's diagnosis on 05/08/14 included lumbar spine herniated nucleus pulposus and gastritis. Per QME report dated 06/21/14, diagnosis was chronic non-radicular spine pain, and on 08/19/14 it was lumbar disc protrusion. The physicians report dated 08/19/14 states that physical therapy and acupuncture provided minimal relief. Medications include Pantoprazole and Tramadol per physicians report dated 08/19/14. MTUS does not discuss functional capacity evaluations. ACOEM chapter 7, page 137-139 states that the "examiner is responsible for determining whether the impairment results in functional limitations... The employer or claim administrator may request functional ability evaluations... may be ordered by the treating or evaluating physician, if the physician feels the information from such testing is crucial." ACOEM further states, "There is little scientific evidence confirming that FCE's predict an individual's actual capacity to perform in the workplace." Per Request for Authorization form dated 08/21/14, the request is made for the diagnosis of lumbar disc protrusion. The physician has not discussed reason for the request. Per ACOEM, there is lack of evidence that FCE's predict a patient's actual capacity. The physician's evaluation and estimation is adequate. Therefore the request is not medically necessary.