

<b>Case Number:</b>	CM15-0018188		
<b>Date Assigned:</b>	02/06/2015	<b>Date of Injury:</b>	12/16/2013
<b>Decision Date:</b>	04/02/2015	<b>UR Denial Date:</b>	12/29/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	01/30/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 44 year old male who sustained a work related injury December 16, 2013. According to a primary treating physician's progress report, dated December 5, 2014, he presented for a follow-up evaluation. He complains of headaches and pain in the neck with radiation and pain in the mid upper and lower back. Diagnostic impression is documented as head pain; cervical spine musculoligamentous strain/sprain with radiculitis, cervical spine discogenic disease with stenosis, thoracic spine musculoligamentous sprain/ strain; lumbar spine musculoligamentous sprain/strain with radiculitis; sleep disturbance secondary to pain and situational depression. Treatment plan includes continue chiropractic therapy; continue prescribed medications, pending MRI authorization and consultation for pain management. According to utilization review dated December 29, 2014, the request for (12) Physical Therapy visits for cervical, thoracic and lumbar spine are non-certified, citing MTUS Chronic Pain Medical Treatment Guidelines. The request for Norco 5/325mg #60 has been modified to Norco 5/325mg # 48, citing MTUS Chronic Pain Medical Treatment Guidelines. The request for Methoderm gel 240g is non-certified, citing MTUS Chronic Pain Medical Treatment Guidelines, Topical Medications, Compounds. The request for MRI of the Lumbar Spine is non-certified, citing MTUS ACOEM Guidelines, Low Back Complaints.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**12 Physical therapy visits for cervical, thoracic and lumbar spine: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper Back (Acute and Chronic).

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

**Decision rationale:** This patient presents with neck and low back pain. The low back pain radiates into the left buttock, thigh, calf and foot. The current request is for 12 PHYSICAL THERAPY VISIT FOR CERVICAL, THORACIC AND LUMBAR SPINE. MTUS guidelines pages 98, 99 states that for "Myalgia and myositis, 9-10 visits are recommended over 8 weeks. For Neuralgia, neuritis, and radiculitis, 8-10 visits are recommended." This patient has a date of injury of 12/16/13. According to progress report dated 6/30/14, "the patient continued going to a clinic and received therapy, but the patient states that the therapy did not really help." There are no physical therapy reports provided for review. The exact number of completed therapy visits to date and the objective response to therapy were not documented in the medical reports. In this case, the request for additional 12 sessions exceeds what is recommended by MTUS. Furthermore, there is no discussion as to why the patient would not be able to participate in a self directed home exercise program. This request IS NOT medically necessary.

**Norco 5/325mg #60: Overturned**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines CRITERIA FOR USE OF OPIOIDS Page(s): 76-78, 88-89.

**Decision rationale:** This patient presents with neck and low back pain. The low back pain radiates into the left buttock, thigh, calf and foot. The current request is for NORCO 5/325 MG 60. The MTUS Guidelines page 76 to 78 under criteria for initiating opioids recommend that reasonable alternatives have been tried, considering the patient's likelihood of improvement, likelihood of abuse, etc. MTUS goes on to states that baseline pain and functional assessment should be provided. Once the criteria have been met, a new course of opioids may be tried at this time. On 8/22/14, the patient was admitted to the emergency room due to "unbearable" pain. The patient was provided with two Norco tablets and discharged in stable condition. The treating physician is attempting to add Norco to the patient's medication regimen. In this case, Tramadol did provide adequate relief and the patient was admitted into the ER. A trial of Norco at this time is within MTUS guidelines. This request IS medically necessary.

**Menthoderm gel 240g: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Medications, Topical NSAIDs.

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

**Decision rationale:** This patient presents with neck and low back pain. The low back pain radiates into the left buttock, thigh, calf and foot. The current request is for MENTHODERM GEL 240G. Mentherm gel contains menthol and methyl salicylate, and NSAID. The MTUS Guidelines page 111 allow for the use of topical NSAID for peripheral joint arthritis and tendinitis. In this case, the patient does not meet the indication for this medication as she suffers from low back and neck pain, which are not considered peripheral arthritis. The requested Methoderm 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): 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 low back chapter, MRI.

**Decision rationale:** This patient presents with neck and low back pain. The low back pain radiates into the left buttock, thigh, calf and foot. The current request is for MRI OF LUMBAR SPINE. For special diagnostics, ACOEM Guidelines page 303 states "unequivocal objective findings that identify specific nerve compromise on the neurological examination is sufficient evidence to warrant imaging in patients who do not respond well to treatment and who would consider surgery as an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study." For this patient's now chronic condition, ODG guidelines provides a thorough discussion. ODG under its low back chapter recommends obtaining an MRI for uncomplicated low back pain with radiculopathy after 1 month of conservative therapy, sooner if severe or progressive neurologic deficit. Progress report dated 3/20/14 states that the patient had a positive MRI of the lumbar spine which revealed "left sided disc herniation eccentric to the left side at L5-S1." The treating physician is requesting a MRI due to the patient continued low back pain and left leg radicular symptoms. ODG further states, "Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation)." There is no new injury, no significant change in examination finding, no bowel/bladder symptoms, and no new location of symptoms that would require additional investigation. The requested repeat MRI of the lumbar spine IS NOT medically necessary.