

<b>Case Number:</b>	CM15-0198351		
<b>Date Assigned:</b>	10/13/2015	<b>Date of Injury:</b>	10/14/2009
<b>Decision Date:</b>	11/20/2015	<b>UR Denial Date:</b>	09/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/08/2015

### 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: Texas, Florida, California

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

### 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 56 year old male with a date of injury on 10-14-2009. The injured worker is undergoing treatment for lumbar intervertebral disc disorder. A pain management physician progress note dated 08-21-2015 documents the injured worker complains of right sacroiliac, lumbar sacral, right buttock, right pelvic, right posterior leg, right posterior knee, right calf, right ankle, right anterior shoulder, left anterior shoulder, left chest and right chest pain. He rates his pain as 5.5 out of 10 and it is noticeable 70% of the time. He has numbness and tingling in the right anterior leg, knee, shin and foot, and right posterior leg, knee, calf, ankle and right foot that is noticed approximately 50% of the time. He complains of dizziness and insomnia. There is cervical tenderness to palpation at the cervical left and right dorsal, upper thoracic, mid thoracic, lumbar, right and left sacroiliac, sacral, left buttock, right buttock, and left and right posterior leg. Cervical range of motion is restricted. There is positive Spurling and cervical compression. Lumbar range of motion is restricted and there is positive Kemps on the right and positive Braggards. Previous treatments were not documented and current medications were not found in documentation provided. The treatment plan includes an updated Magnetic Resonance Imaging of the cervical and lumbar spine, physical therapy to the lumbar spine 2 x week for 3 weeks, Lidall patches to be used as directed and a follow up appointment in 45 days. On 09-15-2015 Utilization Review non-certified the request for Lidall patches (no strength or quantity provided), MRI of the lumbar spine and MRI of the cervical spine.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI of the cervical 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) Repeat imaging.

**MAXIMUS guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Special Studies, and Low Back Complaints 2004, Section(s): Diagnostic Criteria.

**Decision rationale:** This claimant was injured back in 2009, now about 6 years ago. There is pain to multiple areas of the body. Although there is subjective information presented in regarding increasing pain in the neck, there are no accompanying physical signs. The case would therefore not meet the MTUS-ACOEM criteria for cervical, magnetic imaging, due to the lack of objective, unequivocal neurologic physical examination findings documenting either a new radiculopathy, or a significant change in a previously documented radiculopathy. The guides state: 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. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminate imaging will result in false positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. 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) Repeat imaging.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

**Decision rationale:** American College of Occupational and Environmental Medicine, page 303, Low Back Complaints. This claimant was injured back in 2009, now about 6 years ago. There is again pain to multiple areas of the body. Under MTUS/ACOEM, although there is subjective information presented in regarding increasing pain, there are little accompanying physical signs. Even if the signs are of an equivocal nature, the MTUS note that electrodiagnostic confirmation generally comes first. They note "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. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study." The guides warn that indiscriminate imaging will result in false positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. I did not find electrodiagnostic studies. It can be

said that ACOEM is intended for more acute injuries; therefore other evidence-based guides were also examined. The ODG guidelines note, in the Low Back Procedures section: Lumbar spine trauma: trauma, neurological deficit; Lumbar spine trauma: seat belt (chance) fracture (If focal, radicular findings or other neurologic deficit); Uncomplicated low back pain, suspicion of cancer, infection; Uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit. (For unequivocal evidence of radiculopathy, see AMA Guides, 5th Edition, page 382-383.) (Andersson, 2000); Uncomplicated low back pain, prior lumbar surgery; Uncomplicated low back pain, cauda equina syndrome. These criteria are also not met in this case; the request is not medically necessary under the MTUS and other evidence-based criteria.

**Lidall patches (no strength or quantity provided): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

**Decision rationale:** Chronic Pain Medical Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009), page 56 of 127 and page 105 of 127. This claimant was injured back in 2009, now about 6 years ago. There is pain to multiple areas of the body. Lidall patches contain lidocaine and menthol. Topical lidocaine may be recommended for localized peripheral pain after there has been evidence of a trial of first-line therapy (tri-cyclic or SNRI anti-depressants or an AED such as gabapentin or Lyrica). This is not a first-line treatment and is only FDA approved for post-herpetic neuralgia. It is not clear the patient had forms of neuralgia, and that other agents had been first used and exhausted. The MTUS notes that further research is needed to recommend this treatment for chronic neuropathic pain disorders other than post-herpetic neuralgia. Menthol is known as counterirritants. They work by causing the skin to feel cool and then warm. These feelings on the skin distract the patient from feeling the aches/pains deeper in the muscles, joints, and tendons. In this case, these agents are readily available over the counter, so prescription analogues would not be necessary. Further, no strength or quantity is provided and so the clinical appropriateness cannot be assessed. The request is not medically necessary.