

Case Number:	CM15-0202737		
Date Assigned:	10/19/2015	Date of Injury:	07/23/2012
Decision Date:	12/23/2015	UR Denial Date:	09/22/2015
Priority:	Standard	Application Received:	10/15/2015

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: Emergency 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 39 year old female with an industrial injury dated 07-23-2012. A review of the medical records indicates that the injured worker is undergoing treatment for lumbar intervertebral disc disorder (IVD) with myelopathy, lumbar disc herniation with radiculopathy and sciatica. According to the progress notes dated 06-25-2015, 07-21-2015, 08-18-2015, 09-15-2015, the injured worker reported flair up of lumbar spine pain which is worse since last visit. The injured worker reported that the acupuncture makes her pain worse and requests to stop acupuncture. Pain level was 8 out of 10 on a visual analog scale (VAS). Objective findings (06-25-2015, 07-21-2015, 08-18-2015, 09-15-2015) revealed severe left upper quadrant tenderness and positive sitting root on the left. The injured worker was unable to perform toe or heel walk. Magnetic Resonance Imaging (MRI) of lumbar spine dated 12-22-2014 revealed vertebral body hemangioma at L3, desiccation with normal stature at L2- L3 and desiccation with normal stature and central disc protrusion at L4-5 and L5-S1 with narrowing of the left lateral recess. In a pain management consultation report dated 07-30-2015, the injured worker reported left sacroiliac (SI), left lumbar, right lumbar, sacral and left pelvic pain. The injured worker rated pain a 7.5 out of 10, at worst 10 out of 10 and at best a 5 out of 10. The injured worker also reported numbness and tingling in the left anterior leg, left foot and left posterior leg pain, approximately 30% of the time. The injured worker reported insomnia, anxiety and stress. The injured worker feels better with pain medication, topical compound and rest. The symptoms are worse with walking, sitting down, standing up, driving cleaning and cooking. Physical exam (07-30-2015) revealed tenderness to palpitation at bilateral sacroiliac (SI), lumbar, bilateral buttock,

sacral, bilateral posterior legs. Electrodiagnostic study dated 09-10-2015 revealed evidence of mild, chronic L5-S1 radiculopathy on the left and no evidence of peripheral neuropathy in the left lower extremity. Treatment has included Magnetic Resonance Imaging (MRI) of lumbar spine, electrodiagnostic study on 09-10-2015, prescribed medications (Cyclobenzaprine since July of 2015 and Flurbiprofen 20%, Baclofen 2%, Dexamethasone 2%, Menthol 2%, Camphor 2%, Capsaicin 0.0375%, Hyaluronic acid 0.20% in 180 grams since at least April 2015), status post epidural x3, acupuncture therapy, unknown amount of physical therapy and periodic follow up visits. The utilization review dated 09-22-2015, modified the request for physiotherapy 2 sessions (original 2 times a week for 3 weeks, lumbar spine) and non-certified the refer to pain management, refer to spine surgeon, Cyclobenzaprine 5mg #60, Electromyography (EMG) - Nerve conduction velocity (NCV) of LS, Home interferential unit, and FCL - Flurbiprofen 20%, Baclofen 2%, Dexamethasone 2%, Menthol 2%, Camphor 2%, Capsaicin 0.0375%, Hyaluronic acid 0.20% in 180 grams.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physiotherapy 2 times a week for 3 weeks, lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Lumbar & Thoracic (acute & chronic)/Physical therapy.

Decision rationale: The request is for physical therapy. The ODG state the following regarding this topic: ODG Physical Therapy Guidelines allow for fading of treatment frequency (from up to 3 or more visits per week to 1 or less), plus active self-directed home PT. Also see other general guidelines that apply to all conditions under Physical Therapy in the ODG Preface, including assessment after a "six-visit clinical trial". Lumbar sprains and strains: 10 visits over 8 weeks. Sprains and strains of unspecified parts of back: 10 visits over 5 weeks. Sprains and strains of sacroiliac region: Medical treatment: 10 visits over 8 weeks. Lumbago; Backache, unspecified: 9 visits over 8 weeks. Intervertebral disc disorders without myelopathy: Medical treatment: 10 visits over 8 weeks. Post-injection treatment: 1-2 visits over 1 week. Post-surgical treatment (discectomy/laminectomy): 16 visits over 8 weeks. Post-surgical treatment (arthroplasty): 26 visits over 16 weeks. Post-surgical treatment (fusion, after graft maturity): 34 visits over 16 weeks. Intervertebral disc disorder with myelopathy medical treatment: 10 visits over 8 weeks. Post-surgical treatment: 48 visits over 18 weeks. Spinal stenosis: 10 visits over 8 weeks. Sciatica; Thoracic/lumbosacral neuritis/radiculitis, unspecified: 10-12 visits over 8 weeks. Curvature of spine: 12 visits over 10 weeks. Fracture of vertebral column without spinal cord injury: Medical treatment: 8 visits over 10 weeks. Post-surgical treatment: 34 visits over 16 weeks. Fracture of vertebral column with spinal cord injury: Medical treatment: 8 visits over 10 weeks. Post-surgical treatment: 48 visits over 18 weeks. Torticollis: 12 visits over 10 weeks. Other unspecified back disorders: 12 visits over 10 weeks. Work conditioning (See also Procedure Summary entry): 10 visits over 8 weeks. In this case, the request is not guideline-supported. The patient has previously undergone treatment and at this point, self-directed home treatment is advised. As such, the request is not medically necessary.

Refer to pain management: Overturned

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

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)/Office Visits.

Decision rationale: The request is for a pain management consultation. The MTUS guidelines do not address this issue specifically. The ODG state the following regarding this topic. Recommended as determined to be medically necessary. Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible. The ODG Codes for Automated Approval (CAA), designed to automate claims management decision-making, indicates the number of E&M office visits (codes 99201-99285) reflecting the typical number of E&M encounters for a diagnosis, but this is not intended to limit or cap the number of E&M encounters that are medically necessary for a particular patient. Office visits that exceed the number of office visits listed in the CAA may serve as a "flag" to payors for possible evaluation, however, payors should not automatically deny payment for these if preauthorization has not been obtained. Note: The high quality medical studies required for treatment guidelines such as ODG provides guidance about specific treatments and diagnostic procedures, but not about the recommended number of E&M office visits. Studies have and are being conducted as to the value of "virtual visits" compared with inpatient visits, however the value of patient/doctor interventions has not been questioned. (Dixon, 2008) (Wallace, 2004) Further, ODG does provide guidance for therapeutic office visits not included among the E&M codes, for example Chiropractic manipulation and Physical/Occupational therapy. See also Telehealth. In this case, the request is reasonable and supported by the documentation for lumbar intervertebral disc disorder with myelopathy. The patient has chronic pain with inadequate relief seen with a rating of 5 out of 10 with medications at best. This justifies evaluation by a pain management specialist. As such, the request is medically necessary.

Refer to spine surgeon: Upheld

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

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations.

Decision rationale: The request is for specialty consultation. The ACOEM guidelines state the following regarding referral for surgical consultation:- Severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies (radiculopathy), preferably with accompanying objective signs of neural compromise- Activity limitations due to radiating leg pain for more than one month or extreme progression of lower leg symptoms- Clear clinical, imaging, and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair- Failure of conservative treatment to resolve disabling radicular symptoms. Based on the records the patient does have ongoing symptoms and failure of resolution with conservative therapy. There is inadequate documentation of physical exam findings of a change in the patient's neurologic exam. There is also no documentation of clear clinical imaging and electrophysiologic evidence of a lesion that has been shown to benefit from surgical repair. As such, pending further information, the request is not medically necessary.

Cyclobenzaprine 5mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Muscle relaxants (for pain).

Decision rationale: The request is for the use of a muscle relaxant to aid in pain relief. The MTUS guidelines state that the use of a medication in this class is indicated as a second-line option for short-term treatment of acute exacerbations of low back pain. Muscle relaxants may be effective in reducing pain and muscle tension, which can increase mobility. However, in most LBP cases, they show no benefit beyond NSAIDs in pain improvement. Efficacy appears to diminish over time, and prolonged use may lead to dependence. (Homik, 2004) In this case, the use of a muscle relaxant is not guideline-supported. This is secondary to poor effectiveness for chronic long-term use. As such, the request is not medically necessary.

EMG/NCV LS: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

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)/EMGs (electromyography).

Decision rationale: The request is for an EMG. The ODG state the following regarding this topic: Recommended as an option (needle, not surface). EMGs (electromyography) may be useful to obtain unequivocal evidence of radiculopathy, after 1-month conservative therapy, but EMG's are not necessary if radiculopathy is already clinically obvious. (Bigos, 1999) (Ortiz- Corredor, 2003) (Haig, 2005) No correlation was found between intraoperative EMG findings and immediate postoperative pain, but intraoperative spinal cord monitoring is becoming more common and there may be benefit in surgery with major corrective anatomic intervention like fracture or scoliosis or fusion where there is significant stenosis. (Dimopoulos, 2004) EMGs may be required by the AMA Guides for an impairment rating of radiculopathy. (AMA, 2001) (Note: Needle EMG and H-reflex tests are recommended, but Surface EMG and F-wave tests are not very specific and therefore are not recommended. See Surface electromyography.) In this case, the patient does not meet criteria for the study requested. This is secondary to radiculopathy

already diagnosed in the records. Pending receipt of information further clarifying how this would change the management rendered, the study is not medically necessary.

Home interferential unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

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 & thoracic/Interferential therapy.

Decision rationale: The request is for the use of Interferential therapy to aid in pain relief. It has been postulated that Interferential stimulation allows for deeper penetration of tissue, whereas TENS is predominantly a superficial stimulus. The MTUS guidelines states that this is not recommended as an isolated event with lacking quality evidence of effectiveness. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and post-operative knee pain. There is insufficient literature to support Interferential current stimulation for the treatment of these conditions. The ODG guidelines states that its use for low back pain is generally not recommended. In this case the documentation does not support the use of this treatment modality. As such, the request is not medically necessary.

FCL - Flurbiprofen 20%, Baclofen 2%, Dexamethasone 2%, Menthol 2%, Camphor 2%, Capsaicin 0.0375%, Hyaluronic acid 0.20% in 180 grams: Upheld

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

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)/NSAIDs (non-steroidal anti-inflammatory drugs).

Decision rationale: The request is for the use of a medication in the NSAID class. The ODG state the following regarding this topic: Specific recommendations: Osteoarthritis (including knee and hip): Recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Acetaminophen may be considered for initial therapy for patients with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular or renovascular risk factors. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence to recommend one drug in this class over another based on efficacy. In particular, there appears to be no difference between traditional NSAIDs and COX-2 NSAIDs in terms of pain relief. The main concern of selection is based on adverse effects. COX-2 NSAIDs have fewer GI side effects at the risk of increased cardiovascular side effects, although the FDA has concluded that long-term clinical trials are best interpreted to suggest that cardiovascular risk occurs with all NSAIDs and is a class effect (with naproxen being the safest drug). There is no evidence of long-term effectiveness for pain or function. (Chen, 2008) (Laine, 2008) Back Pain - Acute low back pain & acute exacerbations of chronic pain: Recommended as a second-line treatment after acetaminophen. In general, there is conflicting to negative evidence that NSAIDs are more effective than acetaminophen for acute LBP. (van Tulder, 2006) (Hancock, 2007) For patients with acute low back pain with sciatica a recent Cochrane review (including three heterogeneous randomized controlled trials)

found no differences in treatment with NSAIDs vs. placebo. In patients with axial low back pain this same review found that NSAIDs were not more effective than acetaminophen for acute low-back pain, and that acetaminophen had fewer side effects. (Roelofs-Cochrane, 2008) The addition of NSAIDs or spinal manipulative therapy does not appear to increase recovery in patients with acute low back pain over that received with acetaminophen treatment and advice from their physician. (Hancock, 2007) Back Pain - Chronic low back pain: Recommended as an option for short-term symptomatic relief. A Cochrane review of the literature on drug relief for low back pain (LBP) suggested that NSAIDs were no more effective than other drugs such as acetaminophen, narcotic analgesics, and muscle relaxants. The review also found that NSAIDs had more adverse effects than placebo and acetaminophen but fewer effects than muscle relaxants and narcotic analgesics. In addition, evidence from the review suggested that no one NSAID, including COX-2 inhibitors, was clearly more effective than another. (Roelofs-Cochrane, 2008) See also Anti-inflammatory medications. Neuropathic pain: There is inconsistent evidence for the use of these medications to treat long-term neuropathic pain, but they may be useful to treat breakthrough pain and mixed pain conditions such as osteoarthritis (and other nociceptive pain) in patients with neuropathic pain. (Namaka, 2004) (Gore, 2006) See NSAIDs, GI symptoms & cardiovascular risk; NSAIDs, hypertension and renal function; & Medications for acute pain (analgesics). Besides the above well-documented side effects of NSAIDs, there are other less well-known effects of NSAIDs, and the use of NSAIDs has been shown to possibly delay and hamper healing in all the soft tissues, including muscles, ligaments, tendons, and cartilage. (Maroon, 2006) The risks of NSAIDs in older patients, which include increased cardiovascular risk and gastrointestinal toxicity, may outweigh the benefits of these medications. (AGS, 2009) As stated above, acetaminophen would be considered first-line treatment for chronic pain. In this case, the continued use of an NSAID is not supported. This is secondary to inadequate documentation of functional improvement benefit seen. Also, the duration of use places the patient at risk for gastrointestinal and cardiovascular side-effects. In addition, it is known that use of NSAIDs delays the healing of soft tissue including ligaments, tendons, and cartilage. As such, the request is not medically necessary.