

<b>Case Number:</b>	CM15-0038588		
<b>Date Assigned:</b>	03/09/2015	<b>Date of Injury:</b>	10/06/2014
<b>Decision Date:</b>	05/08/2015	<b>UR Denial Date:</b>	02/25/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/02/2015

### 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 38-year-old male who reported an injury on 02/19/2015. The injured worker was reportedly struck in the lower back by a heavy container. The current diagnoses include lumbar radiculopathy, chronic pain syndrome, lumbar contusion, sacroiliac ligament sprain, and lumbar strain. On 02/19/2015, the injured worker presented for an evaluation with complaints of persistent lower back pain. It was noted that the injured worker was initially treated with a course of physical therapy, as well as work restrictions. The injured worker reported radiating symptoms into the bilateral lower extremities. In addition to physical therapy, the injured worker had been treated with anti-inflammatory medication. Upon examination, there was tenderness to palpation over the lower lumbar spine, as well as the bilateral paraspinal muscles, SI joint tenderness, positive faber testing bilaterally; decreased sensation to light touch from L3-S1; normal range of motion with the exception of limited flexion and extension, 4+/5 motor weakness on the right, and positive straight leg raising on the right. Treatment recommendations included an MRI of the lumbar spine and prescriptions for gabapentin 300 mg, cyclobenzaprine 7.5 mg, and Lidoderm 5% patch. The provider also recommended a TENS unit trial. A Request for Authorization form was then submitted on 02/18/2015.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI Lumbar Spine Qty 1.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state if physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause. In this case, it is noted that the injured worker was initially treated with a course of physical therapy, as well as anti-inflammatory medications. However, there is no mention of a recent attempt at any conservative management prior to the request for an imaging study. Given the lack of documented conservative management, the request for an imaging study is not medically necessary at this time.

**Lidoderm Patch 5% (unknown quantity):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical Lidocaine.

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

**Decision rationale:** California MTUS Guidelines state topical lidocaine is recommended following a failure of tricyclic/SSRI antidepressants or anticonvulsants. In this case, there was no mention of a failure of first line oral medication prior to initiation of topical lidocaine. There was also no frequency or quantity listed in the request. Given the above, the request is not medically necessary.

**TEN Unit Qty 1.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 173-174.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-117.

**Decision rationale:** California MTUS Guidelines do not recommend transcutaneous electrotherapy as a primary treatment modality, but a 1 month home based TENS trial may be considered as a noninvasive conservative option. In this case, there was no evidence of a failure of other appropriate pain modalities. The request as submitted also failed to indicate whether the current request for a TENS unit is for a 30-day rental or a unit purchase. The guidelines recommend a 30-day trial prior to a unit purchase. Given the above, the request is not medically necessary at this time.