

<b>Case Number:</b>	CM15-0063140		
<b>Date Assigned:</b>	04/20/2015	<b>Date of Injury:</b>	05/03/2013
<b>Decision Date:</b>	09/10/2015	<b>UR Denial Date:</b>	03/05/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/02/2015

### 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: New York  
 Certification(s)/Specialty: Internal 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 35 year old male, who sustained an industrial injury on 5/03/2013. Diagnoses include lumbar disc protrusion; rule out lumbar radiculitis versus radiculopathy and depression. Treatment to date has included medications, diagnostics and modified activity. Per the Primary Treating Physician's Progress Report dated 2/13/2015, the injured worker reported frequent, moderate, throbbing, achy low back pain and numbness. He also suffers from depression. Physical examination revealed tenderness to palpation and muscle spasm of the lumbar paravertebral muscles and straight leg raise caused pain bilaterally. The plan of care included lumbar traction, diagnostic testing, consultations, chiropractic care, shock wave therapy and physiotherapy. Authorization was requested for a cold/heat therapy unit rental, lumbar brace, TENS unit rental, functional capacity evaluation, physical therapy (2x6) for the lumbar spine, magnetic resonance imaging (MRI) of the lumbar spine, VSNCT lumbar testing, psychological evaluation, DNA testing, radiographic imaging of the lumbar spine, acupuncture (2x6) for the lumbar spine and compound medication.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**RQ Cold/Heat Therapy Unit Rental (duration unspecified): 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), The continuous flow cryotherapy.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): Initial Care, pg 299. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Heat/Cold Packs.

**Decision rationale:** MTUS and ODG recommend at-home local applications of cold in the first few days of acute complaint of pain, followed thereafter by applications of heat or cold. Continuous low-level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. The evidence for the application of cold treatment to low-back pain is more limited than heat therapy. There is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful for pain reduction and return to normal function. MTUS provides no evidence recommending the routine use of high tech devices over the use of local cold or heat wraps. The request for RQ Cold/Heat Therapy Unit Rental (duration unspecified) is not medically necessary by guidelines.

**Lumbar Brace:** 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); Back, Lumbar supports.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): Initial Care, pg 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Lumbar supports.

**Decision rationale:** MTUS states that the use of Lumbar supports to treat low back pain has not been shown to have any lasting benefit beyond the acute phase of symptom relief. Per guidelines, lumbar supports may be recommended as an option for compression fractures and specific treatment of spondylolisthesis and documented instability. Long term use of lumbar supports is not recommended. Chart documentation shows the injured worker complains of chronic low back pain and there is no report of acute exacerbation of symptoms to justify the use of a lumbar support. The request for Lumbar Brace is not medically necessary per guidelines.

**TENS/EMS Unit rental (duration unspecified):** 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); TENS, chronic pain (transcutaneous electrical nerve stimulation).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation), pg 114.

**Decision rationale:** MTUS guidelines state that a TENS unit may be recommended in the treatment of chronic intractable pain conditions, if there is documentation of pain for at least three months duration, evidence that other appropriate pain modalities including medications have been tried and failed and that a one-month trial period of the TENS unit has been prescribed, as an adjunct to ongoing treatment modalities within a functional restoration program. There should be documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; rental would be preferred over purchase during this trial. A treatment plan including the specific short- and long-term goals of treatment with the TENS unit should also be submitted. The injured worker complains of chronic low back pain. Documentation provided fails to show that other appropriate treatment modalities have been tried and failed. The medical necessity for TENS unit trial has not been established. The request for TENS/EMS Unit rental (duration unspecified) is not medically necessary by MTUS.

**Functional Capacity Evaluation:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Functional restoration programs (FRPs), pg 49. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Programs.

**Decision rationale:** Per guidelines, Functional Restorative Programs were designed to use a medically directed, interdisciplinary pain management approach geared specifically to patients with chronic disabling occupational musculoskeletal disorders. They are recommended for patients with conditions that have resulted in delayed recovery. Chart documentation indicates that the injured worker is undergoing active treatment for ongoing low back pain. Not having reached maximum medical therapy at the time of the request under review, guidelines have not been met. The request for R Functional Capacity Evaluation is not medically necessary per guidelines.

**Physical Therapy 2 x 6:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines Page(s): 474.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine, pg 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter.

**Decision rationale:** MTUS and ODG guidelines recommend 10 physical therapy visits over 8 weeks for medical management of Lumbar sprains and strains and intervertebral disc disorders without myelopathy. As time goes, one should see an increase in the active regimen of care or decrease in the passive regimen of care and a fading of treatment of frequency (from up to 3 or more visits per week to 1 or less). When the treatment duration and/or number of visits exceed the guidelines, exceptional factors should be noted. Documentation indicates that the injured

worker is undergoing active treatment for ongoing low back pain. There is lack of evidence of previous initial course of physical therapy or outcome. Although the injured worker could benefit from Physical Therapy, the requested number of visits exceeds that recommended by guidelines and that is no evidence of exceptional factors noted. The request for Physical Therapy 2 x 6 is not medically necessary by MTUS.

**MRI Lumbar Spine:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): Special Studies and Diagnostic and Treatment Considerations, pg 303.

**Decision rationale:** MTUS recommends Lumbar spine x rays in patients with low back pain only when there is evidence of red flags for serious spinal pathology, even if the pain has persisted for at least six weeks. Imaging in patients who do not respond to treatment may be warranted if there are objective findings that identify specific nerve compromise on the neurologic examination and if surgery is being considered 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. The injured worker complains of chronic low back pain and is diagnosed with Lumbar Disc Protrusion. Documentation fails to show objective clinical evidence of specific nerve compromise on the physical examination or acute exacerbation of symptoms. There is lack of Physician report indicating that surgery is being considered. The request for MRI Lumbar Spine is not medically necessary per MTUS.

**VSNCT lumbar testing:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): Special Studies and Diagnostic and Treatment Consideration, page 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck Chapter, Voltage actuated sensory nerve conduction (testing).

**Decision rationale:** Voltage actuated sensory nerve conduction testing (VSCNT) is used to detect neurologic disease. These tests provide a psychophysical assessment of both central and peripheral nerve functions by measuring the detection threshold of accurately calibrated sensory stimuli, and are intended to evaluate and quantify function in both large and small caliber fibers. Per guidelines, there are no clinical studies demonstrating that quantitative tests of sensation improve the management and clinical outcomes of patients over standard qualitative methods of sensory testing. ODG does not recommend Voltage actuated sensory nerve conduction testing (VSCNT) to diagnose sensory neuropathies or radiculopathies. The injured worker complains of chronic low back pain and numbness. Documentation fails to provide objective clinical evidence to support the medical necessity of quantitative nerve conduction testing over standard methods

of sensory testing. The request for VSCNT lumbar testing is not medically necessary per guidelines.

**X-ray lumbar:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): Special Studies and Diagnostic and Treatment Considerations, pg 303.

**Decision rationale:** MTUS recommends Lumbar spine x rays in patients with low back pain only when there is evidence of red flags for serious spinal pathology, even if the pain has persisted for at least six weeks. Imaging in patients who do not respond to treatment may be warranted if there are objective findings that identify specific nerve compromise on the neurologic examination and if surgery is being considered 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. The injured worker complains of chronic low back pain and is diagnosed with Lumbar Disc Protrusion. Documentation fails to show objective clinical evidence of specific nerve compromise on the physical examination or acute exacerbation of symptoms. There is lack of Physician report indicating that surgery is being considered. The request for X-ray lumbar is not medically necessary per MTUS.

**Acupuncture 2 x 6:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints, Chapter 10 Elbow Disorders (Revised 2007), Chapter 11 Forearm, Wrist, and Hand Complaints, Chapter 12 Low Back Complaints, Chapter 13 Knee Complaints, Chapter 14 Ankle and Foot Complaints.

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter.

**Decision rationale:** MTUS states that Acupuncture has not been found to be effective in the management of back pain and is only recommended when used as an adjunct to active physical rehabilitation and/or surgical intervention to hasten functional recovery. Guidelines recommend Initial trial of 3-4 visits over 2 weeks. With evidence of reduced pain, medication use and objective functional improvement, total of up to 8-12 visits over 4-6 weeks. Documentation shows that the injured worker complains of chronic low back pain managed to date with medications and activity modification. There is lack of evidence of previous initial course of acupuncture or outcome. The injured worker could benefit from manual therapy. Per guidelines, the request for Acupuncture 2 x 6 is not medically necessary.

**Gabapentin 15%, Amitriptyline 4%, Dextromethorphan 10% compound 180gm:** Upheld

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

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

**Decision rationale:** MTUS states that use of topical analgesics is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many of these agents. MTUS provides no evidence recommending the use of topical Amitriptyline. Per guidelines, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The request for Gabapentin 15%, Amitriptyline 4%, Dextromethorphan 10% compound 180gm is not medically necessary by MTUS.

**Capsaicin 0.025%, Flurbiprofen 15%, Gabapentin 10%, Menthol 2%, Camphor 2% compound 180gm:** Upheld

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

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

**Decision rationale:** MTUS states that use of topical analgesics is primarily recommended for neuropathic pain when trials of antidepressants and anticonvulsants have failed. There is little to no research to support the use of many of these agents. Flurbiprofen is not FDA approved for topical application and MTUS provides no evidence recommending the use of topical Menthol and Camphor. Furthermore, MTUS does not recommend Gabapentin for use as a topical agent. Per guidelines, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The request for Capsaicin 0.025%, Flurbiprofen 15%, Gabapentin 10%, and Menthol 2%, Camphor 2% compound 180gm is not medically necessary.