

Case Number:	CM14-0210592		
Date Assigned:	12/23/2014	Date of Injury:	03/31/1994
Decision Date:	02/27/2015	UR Denial Date:	12/04/2014
Priority:	Standard	Application Received:	12/16/2014

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: Iowa

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 patient is a male with a date of injury of 3/31/1994 (age was not able to be determined as no date of birth was present on the documentation provided). A review of the medical documentation indicates that the patient is undergoing treatment for low back pain. Subjective complaints (10/28/2014) include episodic low back pain without radiation. Objective findings (10/28/2014) include tenderness to palpation of left buttock, decreased back range of motion, decreased deep tendon reflexes, straight leg raise positive on left, and antalgic gait. Diagnoses include degenerative lumbar disc disease with radiculopathy and myofascial pain syndrome. There were no imaging studies available for review. The patient has previously undergone inversion therapy, laser/TENS units, deep tissue massage, epidural steroid injection, and medication therapy. A utilization review dated 12/4/2014 did not certify the request for six session of myofascial therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Six sessions of myofascial therapy for the lumbar #6: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines manual therapy and manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Massage Therapy Page(s): 60. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Massage Therapy, Manual Therapy; Low Back, Massage.

Decision rationale: The treating physician states that the myofascial therapy in question consists of deep tissue massage. According to MTUS guidelines, massage therapy is recommended in certain circumstances, should be an adjunct to other recommended treatment such as exercise, and should be limited to 4-6 visits in most cases. Evidence on long-term efficacy and follow-up is lacking. ODG recommends massage in general a trial course of 4-6 treatments, 1-2 times per week for the first 2 weeks, and continuing at 1 treatment per week for the next 6 weeks. Maximum duration is recommended at 8 weeks, and treatment beyond this "may be indicated for certain chronic pain patients in whom manipulation is helpful in improving function, decreasing pain and improving quality of life." For low back pain specifically, massage is recommended for a trial of 6 visits over 2 weeks, with evidence of objective functional improvement, up to a total of 18 visits over 6-8 weeks. The medical documentation indicates that the patient completed 12 sessions of therapy in 2011. The treating physician states the patient improved from this, noting ability to sit and walk without pain, and prior notes state that the patient is exercising. Therefore it does appear that the treatment would be an adjunct. The request for six additional sessions would need to meet the criteria for continued therapy. Although the subjective portion of the medical documentation does indicate improvement as self-reported by the patient, the medical documentation contains no clear objective evidence of improvement on physical exam. The patient continued to have pain and decreased range of motion after therapy, with no clear documentation of improvement. Therefore, the request for 6 sessions of myofascial (massage) therapy for lumbar region, is not medically necessary at this time.

Lidoderm 5% patch #30: 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; Lidoderm patches Page(s): 111-113; 56-57. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Topical analgesics.

Decision rationale: According to MTUS guidelines, topical analgesics are primarily recommended for chronic pain in specific circumstances, such as neuropathic pain, when trials of antidepressants and anticonvulsants have failed. MTUS states there is little to no research to support the use of most topical analgesics. ODG guidelines also recommend similar criteria, including identifying a clear indication with a neuropathic etiology and failure of first-line therapy for neuropathy. Both guidelines state therapy should be utilized on a trial basis at first and continued only if significant improvement is noted. Topical lidocaine may be recommended for localized neuropathic pain after there has been evidence of a trial of first-line therapy. This medication is not a first-line treatment for chronic pain and is only FDA approved for post-herpetic neuralgia. ODG states that evidence of localized pain should be consistent with a neuropathic etiology and evidence of a trial of first-line neuropathy medications (anti-

depressants or anti-epilepsy drug) should be included. The medical is not recommended for treatment of osteoarthritis or myofascial pain/trigger points, an area for treatment should be designated as well, and outcomes should be reported. The medical documentation does state the patient has a past diagnosis of post-herpetic neuralgia, and cannot take NSAIDs due to secondary hypertension. However, there is no documentation on the failure of first-line neuropathic medication (antidepressants and anticonvulsants). Also, there is no designated area of treatment or evidence of localized pain other than a reference to low back, but it is unclear what the distinction is between his myofascial/trigger point source and neuropathic source in the low back. There is no documentation of desired or achieved outcomes on this topical medication. Therefore, the request for Lidoderm 5% patch #30, is not medically necessary.