

<b>Case Number:</b>	CM15-0028747		
<b>Date Assigned:</b>	02/20/2015	<b>Date of Injury:</b>	07/31/2014
<b>Decision Date:</b>	05/27/2015	<b>UR Denial Date:</b>	02/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/17/2015

### 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 63 year old individual with an industrial injury dated 07/23/2014. The mechanism of injury is documented as occurring while he was working in a garden when his leg twisted and he injured his low back. The injured worker returned on 01/14/2015 complaining of burning, radicular low back pain radiating into the right buttock and leg. The pain is rated as 5-6/10. He also describes numbness and tingling of the bilateral lower extremities. Physical exam revealed tenderness with spasms in the lumbar paraspinal muscles and over the lumbosacral junction. Range of motion of the lumbar spine was decreased. Straight leg raise was positive at 45 degree. Lumbar spine MRI dated 09/08/2014 is present in the submitted records. Prior treatments included extracorporeal shockwave treatment, medications, physical therapy and acupuncture. Diagnoses: Lumbago, Lumbar spine HNP, Lumbar radiculopathy. On 01/27/2015 utilization review issued the following decisions: The request for pain management consult regarding epidural steroid injections was denied. ACOEM was cited. The request for chiropractic treatment 3 times 6 was denied. MTUS was cited. The request for physical therapy 2 times 6 was denied. MTUS was cited. The request for L/S M back brace was denied. ACOEM was cited. The request for Terocin patches was denied. MTUS was cited.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Pain management consult regarding ESI injections:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): 127.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 92, Chronic Pain Treatment Guidelines Chronic pain programs (functional restoration programs) Page(s): 30-33, 49.

**Decision rationale:** Per MTUS, referral may be appropriate if the practitioner is uncomfortable with treating a particular cause of delayed recovery, or has difficulty obtaining information or agreement to a treatment plan. The goal of such an evaluation is functional recovery and return to work. Multidisciplinary pain programs or Interdisciplinary rehabilitation programs combine multiple treatments, including physical treatment, medical care and supervision, psychological and behavioral care, psychosocial care, vocational rehabilitation and training and education. Per MTUS guidelines, Outpatient pain rehabilitation programs may be recommended if previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement, if the patient has a significant loss of ability to function independently resulting from the chronic pain and if the patient is not a candidate where surgery or other treatments would clearly be warranted. Documentation reveals that the injured worker complains of chronic low back pain and has undergone multiple treatment modalities including chiropractic therapy, acupuncture, physical therapy, extracorporeal shockwave treatment and medications. Physician reports fail to show significant improvement in pain or level or function. With lack of demonstrable significant clinical or functional improvement, the request for Pain Management Consult is reasonable and appropriate. The request for Pain management consult regarding ESI injections is medically necessary.

**Chiropractic treatment 3 times a week for 6 weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy & Manipulation Page(s): 58-60.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter.

**Decision rationale:** MTUS recommends a trial of 6 Chiropractic visits over 2 weeks for initial therapeutic care of low back pain. With evidence of objective functional improvement, a total of up to 18 visits over 6-8 weeks may be prescribed. Per MTUS, elective or maintenance care is not medically necessary. Documentation provided for review reveals that the injured worker was already prescribed 12 sessions of Chiropractic care with no objective improvement in pain or level of function. Given that this injured worker has completed a course of Chiropractic therapy and the lack of physician reports describing specific functional improvement, the medical necessity for further Chiropractic therapy has not been established. The request for Chiropractic treatment 3 times a week for 6 weeks is not medically necessary based on lack of functional improvement and MTUS.

**Physical therapy 2 times a week for 6 weeks:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 99.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Physical Therapy 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. Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Documentation indicates that the injured worker had already been prescribed Physical Therapy, but there is lack of detailed information regarding the number of visits or objective clinical outcome of the treatment. Given that this injured worker has completed a course of physical therapy and the lack of physician reports describing specific functional improvement, the medical necessity for further physical therapy has not been established. The request for Physical therapy 2 times a week for 6 weeks is not medically necessary based on lack of functional improvement and MTUS.

**Lumbar support M back brace:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

**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 does not indicate any acute objective findings to justify the use of lumbar support to treat the injured worker's chronic complaints of back pain. The request for a lumbar flexible brace is not medically necessary.

**Terocin patches:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesic Page(s): 111-112.

**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. Terocin is a topical analgesic containing Lidocaine and Menthol. MTUS provides no evidence recommending the use of topical Menthol. Per guidelines, any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. The request for Terocin patches is not medically necessary.