

<b>Case Number:</b>	CM14-0148617		
<b>Date Assigned:</b>	09/18/2014	<b>Date of Injury:</b>	04/17/2014
<b>Decision Date:</b>	10/22/2014	<b>UR Denial Date:</b>	08/29/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/12/2014

### 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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Illinois. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

### 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 39-year-old male who reported an injury on 04/17/2014 after being pinned in between a wall and a steel table due to sudden movement of the machine. The injured worker reportedly sustained an injury to his left hip, thoracic lumbar spine, and developed lumbar radiculopathy. The injured worker's treatment history included physical therapy, medications, and activity modifications. The injured worker was evaluated on 07/25/2014. It was documented that the injured worker had persistent low back pain rated at a 4/10 to 7/10 with decreased activity levels secondary to pain. It was documented that the injured worker had previously taken Tylenol and Advil; however, this did not contribute to pain control. Physical findings included tenderness to palpation of the bilateral paraspinous regions with restricted range of motion of the thoracic lumbar spine and decreased sensation in the S1 dermatomal distribution. The injured worker had decreased motor strength rated at 4+/5 of the deep tendon reflexes bilaterally. It is documented that the injured worker had undergone x-rays of the lumbar spine on 07/25/2014 that documented a moderate disc space narrowing at the L5 S1 and multilevel anterior and posterior osteophytes. The injured worker's diagnoses included left hip hematoma, thoracic lumbar spine sprain/strain, and lumbar radiculopathy. The injured worker's treatment plan included chiropractic treatments of the lumbar spine, medications, and an MRI of the lumbar spine. A Request for Authorization form was submitted on 07/25/2014 to support the request.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI LUMBAR SPINE: Overturned**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 52-59. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG)

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

**Decision rationale:** The request of the MRI of the lumbar spine is medically necessary and appropriate. The American College of Occupational and Environmental Medicine recommend MRIs for clinically evident radiculopathy that has failed to respond to conservative treatment. The clinical documentation submitted for review does indicate that the patient has findings of radiculopathy that has failed to respond to conservative treatment and activity modifications. The clinical documentation does indicate that the patient underwent an abdominal MRI. Although in some instances, the lumbar spine that would be observed on the imaging of this type of MRI, the independent report provided did not address the lumbar spine. Therefore, pathology cannot be determined by the abdominal MRI scan. Given this information, an MRI of the lumbar spine would be supported in this clinical situation. As such the requested MRI of the lumbar spine is medically necessary and appropriate.

**MENTHODERM GEL 4 OUNCES (DISPENSED): Upheld**

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

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

**Decision rationale:** California Medical Treatment Utilization Schedule recommends topical analgesics for patients who have failed to respond to first line medications such as anticonvulsants and antidepressants. The clinical documentation does indicate that the patient has failed to respond to over the counter medications to include Tylenol and Advil. However, there is no documentation that the patient has been unresponsive to other first line medications to include antidepressants and anticonvulsants. Therefore, the use of a topical agent would not be supported in this clinical situation. Furthermore, the request as it is submitted does not clearly identify a frequency of treatment or applicable body part. In the absence of this information, the appropriateness of the request itself cannot be determined. As such the requested Menthoderm gel 4 oz is not medically necessary or appropriate.

**CYCLOBENZAPRINE 7.5MG #30 (DISPENSED): Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 63.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

**Decision rationale:** California Medical Treatment Utilization Schedule recommends short courses of treatment of muscle relaxants to assist with acute exacerbations of chronic pain. The clinical documentation submitted for review does not provide any evidence of a treatment history using this medication. Therefore, an initial prescription would be supported. However, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information the appropriateness of the request itself cannot be determined. As such the requested cyclobenzaprine 7.5 mg #30 is not medically necessary or appropriate.

**CHIROPRACTIC X 8 VISITS (LUMBAR):** 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 Manual Therapy and Manipulation Page(s): 58.

**Decision rationale:** The requested CHIROPRACTIC X 8 VISITS (LUMBAR) visits are not medically necessary or appropriate. California Medical Treatment Utilization Schedule recommends manual therapy and manipulation for patients who have persistent low back pain. The clinical documentation does not provide any evidence that the patient has had any treatment history of this modality. California Medical Treatment Utilization Schedule recommends an initial trial of 6 visits to establish efficacy of treatment. The request exceeds this recommendation. There are no exceptional factors noted to support extending treatment beyond guideline recommendations. As such the requested CHIROPRACTIC X 8 VISITS (LUMBAR) is not medically necessary or appropriate.

**LABS (36451, 99001, 99002, 99195, 99199, 86890):** 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 NSAIDs, hypertension and renal function Page(s): 69.

**Decision rationale:** California Medical Treatment Utilization Schedule recommends lab monitoring for patients after 4 to 8 weeks of initiating nonsteroidal anti-inflammatory drug therapy. The clinical documentation does not provide a treatment history to include nonsteroidal anti-inflammatory drug usage for at least 4 to 8 weeks. The clinical documentation does indicate that the use of ketaprofen was initiated. However, the need for lab testing at initiation of drug usage is not supported. As such, the requested labs 36451, 99001, 99002, 99195, 99199, 86890 are not medically necessary or appropriate.