

Case Number:	CM13-0042000		
Date Assigned:	12/20/2013	Date of Injury:	04/24/2007
Decision Date:	06/04/2014	UR Denial Date:	10/04/2013
Priority:	Standard	Application Received:	10/15/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Anesthesiologist, Pain Medicine and is licensed to practice in Florida. 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 physician 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 58-year-old male who reported a work related injury on 04/24/2007 as a result of a fall. The only clinical note submitted for review is a qualified medical re-evaluation of the patient dated 02/07/2013 by [REDACTED] which reported the patient had not returned to work since the date of injury. The patient presents with the following diagnoses, burst fracture of L2 vertebral body with fragment extrusion into spinal canal, lumbosacral spinal canal stenosis, status post MRSA postsurgical infection lumbosacral spine, osteomyelitis lumbosacral spine, sprain and strain of the lumbosacral spine, lumbar radiculopathy, status post L2 corpectomy with lumbar spine stenosis L2-5, status post irrigation, debridement, and hardware removal via retroperitoneal approach, status post fusion T12-L4, erectile dysfunction, depression and anxiety. The provider documented upon physical exam of the patient range of motion of the lumbar spine cannot be measured secondary to the patient's pain level, straight leg raise testing was positive bilaterally at 30 degrees.

IMR ISSUES, DECISIONS AND RATIONALES

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

ACUPUNCTURE 2 X 8 LUMBAR SPINE: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The Physician Reviewer's decision rationale: The current request is not supported. California MTUS Acupuncture Guidelines indicate, acupuncture is used as an option when pain medication is reduced or not tolerated, may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Time to produce functional improvement is 3 to 6 treatments. The current request is excessive in nature. Additionally, given that the patient is status post his work related injury of over 6 year's time; it is unclear if the patient has previously utilized acupuncture and the efficacy of treatment. Furthermore, the clinical notes failed to evidence a recent physical exam of the patient. Given all the above, the request for acupuncture 2 x 8 lumbar spine is not medically necessary nor appropriate.

TENS UNIT: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 116.

Decision rationale: The Physician Reviewer's decision rationale: The current request is not supported. California MTUS indicates a 1 month trial period the TENS unit should be documented as an adjunct to ongoing treatment modalities within a functional restoration approach with 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. There was no clinical documentation submitted for review other than a QME evaluation by [REDACTED] dated from 02/2013. Rationale for this DME at this point in the patient's treatment was not evidenced in the clinical notes reviewed. Furthermore, it is unclear if the patient has utilized a recent trial of this modality and the efficacy of this intervention for the patient's pain complaints. Given all the above, the request for TENS unit is not medically necessary or appropriate.

FUNCTIONAL RESTORATION PROGRAM (NO FREQUENCY OR DURATION PROVIDED): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 31-32.

Decision rationale: The Physician Reviewer's decision rationale: The current request is not supported. California MTUS indicates specific criteria must be met upon entrance into a chronic pain management program to include an adequate and thorough evaluation has been made including baseline functional testing so follow-up with the same test can note functional improvement. The clinical notes did not evidence a recent thorough physical exam of the patient, psychological evaluation of the patient, the patient's current pain medication regimen, or duration

of treatment in a chronic pain management program. Given all the above, the request for Functional Restoration Program (no frequency or duration provided) is not medically necessary or appropriate.

RETRO TRIGGER POINT INJECTIONS X 10 LUMBAR, DOS: 9/12/2013: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 122.

Decision rationale: The Physician Reviewer's decision rationale: The request is not supported. California MTUS indicates specific criteria for use of trigger point injections to include: (2) documentation of circumscribed trigger points with evidenced upon palpation of a twitch response, as well as referred pain; (2) symptoms have persisted for more than 3 months; (3) medical management therapy such as ongoing stretching exercises, physical therapy, NSAIDs, and muscle relaxants have failed to control pain; (4) radiculopathy is not present by exam or imaging or neuro testing; (5) not more than 3 to 4 injections per session are administered; (6) no repeat injections unless greater than 50% pain relief is obtained for 6 weeks after an injection and there is documented evidence of functional improvement. Given the lack of documentation evidencing exhaustion of lower levels of conservative treatment, evidence of palpation of a twitch response, as well as referred pain, in addition to lack of documentation of the patient having myofascial pain syndrome x3 months, the request for retro Trigger Point Injections x 10 lumbar, DOS: 9/12/2013 is not medically necessary or appropriate.