

Case Number:	CM13-0051725		
Date Assigned:	12/27/2013	Date of Injury:	09/27/2013
Decision Date:	08/15/2014	UR Denial Date:	10/31/2013
Priority:	Standard	Application Received:	11/14/2013

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 & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 injured worker is a 46-year-old male who reported an injury on September 27, 2013, which was stated as cumulative. The injured worker stated injuries to the back were caused during the course of performing his normal job duties, which included but were not limited to lifting and carrying approximately 25 to 50 pounds of various materials, loading and unloading cargo trucks, climbing up and down ladders, repetitive bending and crouching. The injured worker had complaints of constant pain in his lower back that traveled to the left anterior thigh into the knee, which he described as aching, stabbing and sore. The injured worker rated his pain as an 8/10. The injured worker also stated he experiences occasional tingling in his back, and occasional weakness in his left leg. The injured worker stated that medication helped reduce pain to a 3/10. The injured worker also complained of difficulty falling asleep due to pain, waking during the night due to pain, headaches, and symptoms of depression due to pain or loss of work, decreased muscle mass and strength, decreased energy levels, numbness with pain described as tingling. He also stated the pain was aggravated with prolonged sitting, prolonged standing, prolonged walking, repetitive bending, repetitive stooping, repetitive kneeling, twisting, lifting, carrying, pulling, and climbing. The injured worker stated his pain was reduced with rest, cold and ice. He was also using a lumbar support. The injured worker was using a transcutaneous electrical nerve stimulation unit at home. Medications for the injured worker were Tylenol 500mg, Atenolol 50mg, tramadol 150mg, cyclobenzaprine 7.5mg, Pantoprazole 20mg. The injured worker had an MRI of the lumbar spine on October 21, 2013, which revealed L3-4 disc level showed dehiscence of the nucleus pulposus with a 4 mm midline disc bulge indenting the anterior portion of the lumbosacral sac with minimal decrease in the anteroposterior (AP) sagittal diameter of the lumbosacral canal. Mild bony hypertrophy of the bilateral articular facets were noted as well as

minimal thickening of the ligamentum flavum. The injured worker had an electromyogram (EMG) on October 30, 2013, which was suggestive of irritation of the left L5 nerve root. Nerve conduction findings were normal. The injured worker had an examination with an orthopedic surgeon on June 10, 2014, which revealed the injured worker was able to sit, stand and walk without any apparent difficulty. The injured worker had no postural abnormality. Palpation of the low back was tender. Peripheral pulses on the foot were intact. It was noted the injured worker was not cooperative with several parts of the examination. Range of motion of the low back was tested and that was associated with sign of overreaction and possibly secondary again. The injured worker used the inclinometer and was not able to flex more than 15 degrees, extend more than 5 degrees or perform lateral bending more than 5 degrees toward the left and 15 degrees toward the right. It was noted in the report signs of overreaction was noted when the injured worker avoided rotation of the low back complaining of severe pain and the rotation was limited to less than 10 degrees. The injured worker complained of severe low back pain during the testing of the range of motion of the low back but prior to that when the examiner requested the injured worker about the nature of unloading activities at his work, the injured worker showed significantly better motion and lack of any significant low back pain or any other complaints. It was also noted that the injured worker was demonstrating his work activities and showed reasonable good motion of the low back including partial bending and some twisting of the back during demonstration. Neurological examination sensation to monofilament according to Semmes Weinstein method and pinwheel of lower extremity were intact. The injured worker had a normal gait and was able to heel and toe walk briefly, but on toe raises after six, he complained of having back pain. Individual muscle groups of the lower extremity revealed 5/5 strength. The tension signs were tested and they were associated with major overreaction. The straight leg raising to about 40 degrees caused pain on both sides and then by bending the knee and the hip toward full flexion, the pain increased. Then by extending the leg further, the injured worker complained of back pain, but by forcing the ankle to dorsiflexion, back pain improved. Additionally, the reflexes were brisk at the patella and the Achilles and symmetrical. It was noted further sign of overreaction were complaints of severe back pain when the injured worker was on his back, hip and knee flexed and rotation of the hip toward medial and lateral direction performed. The pain was not localized to the sacroiliac joint and was in the mid back area. X-rays for the injured worker revealed degenerative discectomy of the low back at multiple levels was noted with no significant disc space diminution. There was calcification of the anterior longitudinal ligament in L1-2 and no spondylosis or spondylolisthesis. Diagnosis was degenerative discectomy of the low back. The rationale and Request for Authorization were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pain Management Referral: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, Chapter 6: Pain, Suffering and the Restoration of Function, page(s) 115.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Introduction Page(s): 1.

Decision rationale: The request for a pain management referral is not medically necessary. The injured worker's primary care physician is a chiropractor. The reports sent in by the primary care were very difficult to read. It was not noted that the injured worker was prescribed any medications for pain relief on the first visit. First examination was on October 09, 2013 where the injured worker's primary care referred for an MRI, nerve conduction study/electromyography, pain management, psych, and Functional Capacity Evaluation. It was not documented that any type of conservative care was initiated to the injured worker. The California MTUS guidelines state that if the complaint persists, the physician needs to reconsider the diagnosis and decide whether a specialist evaluation is necessary. Medical necessity of the request to be referred to pain management has not been established. The injured worker did have several chiropractic visits and acupuncture with statements from the injured worker of some relief of pain. The examination findings submitted were conflicting as to the severity of the injured worker's pain complaints and functional deficits due to the pain. Therefore, given there is a lack of details supporting an adequate trial of conservative care has been provided and given the lack of consistent pain complaints and functional deficits, the request to be referred to pain management is not medically necessary.

Psych Referral: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 398.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines
Psychological Evaluations Page(s): 100.

Decision rationale: The request for a psych referral is not medically necessary. The injured worker mentioned he had depression due to pain and loss of work. The injured worker was evaluated by an orthopedic surgeon on June 10, 2014 who revealed that the injured worker was overreacting during physical examination. Physical examination findings did not correlate with the pain management examination, which was on the same day. The California MTUS guidelines state psychological evaluations are recommended and should determine if further psychological interventions are indicated. The medical necessity of the request has not been established. It was noted that the injured worker was feeling depressed; however, objective information pertaining to the injured worker's symptoms and length of time the symptoms have been present was not provided to support the request for a psychological referral. Therefore, the request is not medically necessary.

MRI (Magnetic Resonance Imaging): 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): 303-305.

Decision rationale: The request for an MRI is not medically necessary. The California/ACOEM suggest unequivocal objective findings that identify specific nerve compromise on the neurological examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. On the most recent examination of the injured worker, there were no neurological deficits on examination to support the necessity of the MRI. The request as submitted did not indicate the area of the body the MRI was being requested for. Therefore, the request is not medically necessary.

EMG (Electromyography): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

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

Decision rationale: The request for an EMG is not medically necessary. The California/ACOEM Guidelines suggest that electromyography (EMG), including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in injured workers with low back symptoms lasting more than 3 or 4 weeks. There was no objective evidence of neurological deficits on examination to indicate the medical necessity for the referral. The request as submitted failed to provide the area of the body the study was being requested for. The injured worker does not meet the criteria set forth. Therefore, the request is not medically necessary.

NCV (Nerve Conduction Velocity): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Nerve conduction studies (NCS).

Decision rationale: The request for an NCV is not medically necessary. The California/ACOEM Guidelines suggests that electromyography, including H-reflex tests, may be useful to identify subtle, focal neurologic dysfunction in injured workers with low back symptoms lasting more than 3 or 4 weeks. The Official Disability Guidelines state a nerve conduction study is not recommended. There was no objective evidence of neurological deficits on examination to indicate the medical necessity for the referral. The request as submitted did not provide the area of the body the study was requested for. The injured worker does not meet the criteria set forth. Therefore, the request is not medically necessary.

Functional Capacity Evaluation (FCE): 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).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Fitness For Duty, Functional Capacity Evaluation.

Decision rationale: The request for a FCE is not medically necessary. The California/ACOEM guidelines suggest that there are a number of functional assessment tools for reassessing function and functional recovery, including Functional Capacity Exams and videotapes. The Official Disability Guidelines suggest that for a FCE, which it is recommended prior to admission to a work hardening program, with preference for assessments tailored to a specific task or job. Functional Capacity Evaluations are also for case management that is hampered by complex issues, such as prior unsuccessful return to work attempts, conflicting medical reporting on precautions and/or fitness for modified job and injuries that require detailed exploration of a worker's abilities. The guidelines also state not to proceed with a Functional Capacity Evaluation if the sole purpose is to determine a worker's effort or compliance or if the worker has returned to work and an ergonomic assessment has not been arranged. A Functional Capacity Evaluation is usually recommended prior to admission to a work hardening program. The injured worker does not meet the guidelines set for a Functional Capacity Evaluation test. The injured worker has not tried to return to work, due to being fired. There is a lack of rationale provided for the requested FCE, as the injured worker does not currently have a job to return to. Therefore, the request is not medically necessary.

Exercise/ Physical Therapy (12-sessions): 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 Physical Medicine Page(s): 98, 99.

Decision rationale: The request for exercise/physical therapy is not medically necessary. The California MTUS Guidelines state that active therapies are based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function and range of motion and can alleviate discomfort. Injured workers are instructed in and expected to continue with active therapies at home as an extension of the treatment process in order to maintain improvement levels. The guidelines allow for a fading of treatment frequency, from up to three visits per week to one or less, plus active, self-directed home physical medicine. For unspecified myalgia and myositis, 9 to 10 visits over an 8-week period are recommended. For unspecified neuralgia, neuritis and radiculitis, 8 to 10 visits over a 4-week period are recommended. The request exceeds the guideline recommendations of 8-10 visits. There was a lack of objective deficits regarding range of motion and strength to support the necessity of the requested therapy. In addition, the request as submitted failed to indicate the area of the body the therapy was requested for. Therefore, the request is not medically necessary.

Biofeedback Therapy (12-visits): 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 Biofeedback Page(s): 24, 25.

Decision rationale: The request for biofeedback therapy visits is not medically necessary. The California MTUS guidelines state that for biofeedback that it is not recommended as a standalone treatment, but is recommended as an option in a cognitive behavioral therapy program to facilitate exercise therapy and a return to activity. Evidence is insufficient to demonstrate the effectiveness of biofeedback for the treatment of chronic pain. The injured worker does not have a request to be in a cognitive behavioral therapy program to be performed with the biofeedback request. There is a lack of objective psychological deficits provided to support the necessity of the biofeedback therapy. The medical necessity of the request has not been established. Guidelines also recommend a trial of 3-4 sessions to determine efficacy and the request exceeds these recommendations. Therefore, the request is not medically necessary.

Acupuncture (12-sessions): Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: The request for acupuncture is not medically necessary. The California MTUS Guidelines state that acupuncture is the stimulation of specific acupoints along the skin of the body involving various methods, such as penetration by thin needles or the application of heat, pressure or laser light. Traditional acupuncture involves needle insertion, moxibustion and cupping therapy. The Acupuncture aims to treat a range of conditions, though it is most commonly used for pain relief. The Acupuncture Medical Treatment Guidelines state that the frequency and duration of acupuncture or acupuncture with electrical stimulation is 3 to 6 visits. The frequency is 1 to 3 times per week, and the optimum duration is 1 to 2 months. Acupuncture treatments may be extended if functional improvement is documented. The request exceeds the recommended 3 to 6 visits. Guidelines also state acupuncture is used as an option when pain medication is reduced or not tolerated. The clinical information submitted failed to indicate the injured worker's pain medication was being reduced or was not tolerated. Therefore, the request is not medically necessary.

Chiropractic Care (12-sessions): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298, Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58.

Decision rationale: The request for chiropractic care is not medically necessary. California MTUS Guidelines state the intended goal of manual medicine is the achievement of positive symptomatic or objective measurable gains in functional improvement that facilitate progression in a therapeutic exercise program. The California MTUS guidelines state that manual therapy is recommended for chronic pain if caused by musculoskeletal conditions. For low back pain, it is recommended as an option for a trial of six visits over a two-week period; and with evidence of objective functional improvement documented, and then a total of eighteen visits over a six to eight-week period shall be recommended. The guidelines recommend three to six visits. If there is documented functional improvement more sessions will be certified. The request exceeds the recommended three to six visits. In addition, there was a lack of objective deficits to support the necessity of the requested chiropractic therapy. The request as submitted failed to provide the area of the body the therapy was requested for. Therefore, the request is not medically necessary.