MAXIMUS Federal Services

Case Number:	CM14-0007648		
Date Assigned:	05/02/2014	Date of Injury:	07/03/2006
Decision Date:	07/09/2014	UR Denial Date:	12/27/2013
Priority:	Standard	Application Received:	01/21/2014

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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in California. 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 56-year-old male who has filed a claim for lumbar spine radiculitis associated with an industrial injury date of July 03, 2006. Review of progress notes reports low back pain radiating into the bilateral buttocks, and predominantly into the left lower extremity down to the level of the ankle. Findings include decreased lumbar range of motion, mildly antalgic gait, decreased sensation in the L5 and S1 dermatomes, decreased ankle and knee reflexes, difficulty with heel-toe walking, and positive straight leg raise on the left. EMG of the lower extremities from January 19, 2012 showed evidence of chronic left L5-S1 polyneuropathy. Lumbar MRI, dated April 04, 2012, showed post-operative changes at L4-5; and disc desiccation, facet degenerative changes, and disc protrusions at L2-3 and L3-4 with no spinal stenosis. Treatment to date has included NSAIDs, opioids, gabapentin, Soma, Flector patches, Lidoderm, back bracing, and lumbar epidural steroid injection. Patient had lumbar spine surgery in 2006, and again in January 2007 with post-operative physical therapy. Current medications include Norco, Neurontin, and Celebrex. Utilization review from December 27, 2013 denied the requests for MRI of the lumbar spine, Theracane, acupuncture x8, and PT aqua therapy 2-3 times per week for 4-6 weeks (18 sessions). Reasons for denial were not made available.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI LUMBAR SPINE: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) LOW BACK CHAPTER, MRIS (MAGNETIC RESONANCE IMAGING).

Decision rationale: The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, and ODG was used instead. According to ODG, lumbar MRIs are recommended in patients with lumbar spine trauma with neurological deficit or seatbelt fracture; uncomplicated low back pain with prior lumbar surgery, or with cauda equina syndrome; or myelopathy -- traumatic, painful, sudden onset, or progressive. In this case, there is no documentation regarding worsening of patient's low back pain and radiculopathy or of failure of conservative therapy to support the need for a lumbar MRI at this time. Therefore, the request for lumbar MRI was not medically necessary per the guideline recommendations of ODG.

THERACANE: 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 Page(s): 60. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) KNEE AND LEG CHAPTER, DURABLE MEDICAL EQUIPMENT (DME). OTHER MEDICAL TREATMENT GUIDELINE OR MEDICAL EVIDENCE: THERA CANE HTTP://WWW.THERACANE.COM/INDEX.HTML.

Decision rationale: An online search indicates that TheraCane is a deep pressure massager to treat trigger points associated with myofascial pain syndrome. Pressure applied to the muscles by the TheraCane helps to maximize the flow of oxygenated blood to the muscles, aiding in restoring muscle function by breaking up adhesions in muscle fibers and tendons. According to CA MTUS, massage therapy is recommended as an adjunct to other recommended treatment in attenuating diffuse musculoskeletal symptoms. There is lack of long-term benefit. According to ODG, durable medical equipment (DME) is recommended if there is a medical need. In this case, the patient does not present with symptoms of myofascial pain syndrome or of diffuse musculoskeletal symptoms to warrant massage therapy. There is no clear indication as to the necessity of a TheraCane. Therefore, the request for TheraCane was not medically necessary per the guideline recommendations of CA MTUS.

ACUPUNCTURE X8 TREATMENTS: Upheld

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines,Chronic Pain Treatment Guidelines Pain, Suffering, and the Restoration of Function Page(s): 114.

Decision rationale: As stated on page 114 of the ACOEM Pain, Suffering, and the Restoration of Function Guidelines referenced by CA MTUS, the importance of a time-limited treatment plan with clearly defined functional goals, frequent assessment and modification of the treatment plan based upon the patient's progress, and monitoring from the treating physician are paramount. In addition, CA MTUS Acupuncture Medical Treatment Guidelines state that acupuncture may be used as an option when pain medication is reduced or not tolerated, as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Guidelines state that the time to produce functional improvement is 3 - 6 treatments. In this case, there is no documentation of intolerance to or failure of pain medications, or a current physical rehabilitation program that the patient is engaged in. Also, the body part to be treated is not specified. The request for acupuncture x 8 treatments was not medically necessary per the guideline recommendations of CA MTUS.

PT AQUATHERAPY 2-3 TIMES PER WEEK FOR 4-6 WEEKS (QTY:18.00): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines AQUATIC THERAPY Page(s): 22.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22, 29.

Decision rationale: According to page 22 of CA MTUS Chronic Pain Medical Treatment Guidelines, aquatic therapy is recommended as an optional form of exercise therapy as an alternative to land-based physical therapy when reduced weight bearing is indicated, such as with extreme obesity. According to the Physical Medicine Guidelines on page 99 of CA MTUS Chronic Pain Medical Treatment Guidelines, the recommended schedule is 8-10 visits over 4 weeks. In this case, patient's BMI as per August 2013 was 35, which corresponds to Class II obesity. However, there is no documentation regarding expected goals and functional gains of physical therapy in this patient. Also, the requested number of sessions exceeds guideline recommendations. Therefore, the request for PT aqua therapy 2-3 times per week for 4-6 weeks (qty: 18) was not medically necessary per the guideline recommendations of CA MTUS.