

Case Number:	CM14-0112085		
Date Assigned:	09/16/2014	Date of Injury:	07/23/2013
Decision Date:	10/16/2014	UR Denial Date:	07/02/2014
Priority:	Standard	Application Received:	07/18/2014

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 Occupational Medicine, 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:

Injured worker is a male with date of injury 7/23/2013. Per primary treating physician's progress report dated 6/18/2014, the injured worker states his symptoms have not improved since last seen. He describes his back pain as 7/10, constant, burning, but less at night. He persists with cramping episodes of both thighs and calves that are worse and cause him to limp with the right lower extremity. He states he has had 3 episodes of sudden weakness of his lower extremities with 3 falls forward. The pain can radiate to bilateral thoracic paraspinal areas. The numbness/tingling of his lower extremities has resolved. He had one episode of urinary incontinence. He denies any saddle anesthesia. He describes a burning sensation to both testicles. He states the medications have helped as well as physical therapy three times a week. He is doing home exercise program. Right shoulder pain is less, 5/10 versus 7/10 intermittent and burning. He states the numbness and weakness of the right upper extremity are also less. Neck pain resist with radiating pain down his right upper extremity with weakness. It is described as a 6/10 and constant and can get sharp. Depression and anxiety are improved with Zoloft. GERD is controlled with omeprazole. On examination back flexion is 45 degrees, extension is 25 degrees. Straight leg raising is positive at 20 degrees on right and 40 degrees on left. EHL is positive on right. He is very tender to percussion over L4, L5 and S1. Gait is antalgic. Neck is tender to both paraspinal cervical areas, more on right, both trapezii and paraspinal thoracic areas. Flexion is 40 degrees, side bending 45 degrees left and 40 degrees right. Right shoulder is tender to RTC, biceps groove and deltopectoral area. Range of motion is abduction 140 degrees, rotations full, extension 45 degrees. Impingement is positive. Diagnoses include 1) chronic low back pain 2) congenital tethered cord status post surgery 2/26/2014 3) lumbar radiculopathy with weakness of legs with falls x3 4) lumbar strain with trauma to lower back and contusion of coccyx 5) urinary frequency 6) neck pain/strain with cervical radiculitis on right 7) right shoulder strain.

IMR ISSUES, DECISIONS AND RATIONALES

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

Trigger Point Injections (TPT): 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 Trigger Point Injections section Page(s): 122.

Decision rationale: The MTUS Guidelines recommend the use of myofascial pain syndrome as indicated, with limited lasting value. It is not recommended for radicular pain. Trigger point injections with an anesthetic such as bupivacaine are recommended for non-resolving trigger points, but the addition of a corticosteroid is not generally recommended. A trigger point is a discrete focal tenderness located in a palpable taut band of skeletal muscle, which produces a local twitch in response to stimulus to the band. Trigger points may be present in up to 33-50% of the adult population. Myofascial pain syndrome is a regional painful muscle condition with a direct relationship between a specific trigger point and its associated pain region. These injections may occasionally be necessary to maintain function in those with myofascial problems when myofascial trigger points are present on examination. Trigger point injections are not recommended for typical back pain or neck pain. For fibromyalgia syndrome, trigger point injections have not been proven effective. Trigger point injections with a local anesthetic may be recommended for the treatment of chronic low back or neck pain with myofascial pain syndrome when all of the following criteria are met: (1) Documentation of circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain; (2) Symptoms have persisted for more than three months; (3) Medical management therapies such as ongoing stretching exercises, physical therapy, NSAIDs and muscle relaxants have failed to control pain; (4) Radiculopathy is not present (by exam, imaging, or neuro-testing); (5) Not more than 3-4 injections per session; (6) No repeat injections unless a greater than 50% pain relief is obtained for six weeks after an injection and there is documented evidence of functional improvement; (7) Frequency should not be at an interval less than two months; (8) Trigger point injections with any substance (e.g., saline or glucose) other than local anesthetic with or without steroid are not recommended. The medical necessity of this request has not been established within the recommendations of the MTUS Guidelines. The request for Trigger Point Injections is not be medically necessary.

Depression Evaluation: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Chapter 5, page(s) 78, 79, 90

Decision rationale: Per the MTUS Guidelines, the clinician acts as the primary case manager. The clinician provides medical evaluation and treatment and adheres to a conservative evidence-based treatment approach that limits excessive physical medicine usage and referral. The clinician should judiciously refer to specialists who will support functional recovery as well as provide expert medical recommendations. Referrals may be appropriate if the provider is uncomfortable with the line of inquiry, with treating a particular cause of delayed recovery, or has difficulty obtaining information or agreement to a treatment plan. The requesting physician reports that depression and anxiety have improved with the use of Zoloft. There are no acute complaints, examination findings, or expressed concern by either the injured worker or requesting physician in regards to depression management. Medical necessity for this request has not been established. The request for Depression Evaluation is determined to not be medically necessary.

Sexual Function Evaluation: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Chapter 5, page(s) 78, 79, 90

Decision rationale: Per the MTUS Guidelines, the clinician acts as the primary case manager. The clinician provides medical evaluation and treatment and adheres to a conservative evidence-based treatment approach that limits excessive physical medicine usage and referral. The clinician should judiciously refer to specialists who will support functional recovery as well as provide expert medical recommendations. Referrals may be appropriate if the provider is uncomfortable with the line of inquiry, with treating a particular cause of delayed recovery, or has difficulty obtaining information or agreement to a treatment plan. The requesting physician does not describe or explain the sexual dysfunction that the injured worker has or why an evaluation for sexual function is indicated. Medical necessity for this request has not been established. The request for Sexual Function Evaluation is determined to not be medically necessary.

Psychologist Cognitive Behavioral 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 Behavioral Interventions section.

Decision rationale: Per the MTUS Guidelines, behavioral interventions are recommended. The identification and reinforcement of coping skills is often more useful in the treatment of pain than ongoing medication or therapy, which could lead to psychological or physical dependence. The criteria for use of cognitive behavior therapy (CBT) for chronic pain include (1) Screen for patients with risk factors for delayed recovery, including fear avoidance beliefs (2) Initial therapy

for these "at risk" patients should be physical medicine for exercise instruction, using a cognitive motivational approach to physical medicine (3) Consider separate psychotherapy CBT referral after 4 weeks if lack of progress from physical medicine alone with an initial trial of 3-4 psychotherapy visits over 2 weeks. With evidence of objective functional improvement, total of up to 6-10 visits over 5-6 weeks (individual sessions) are recommended. This request is in excess of the number of visits recommended by the MTUS Guidelines as an initial trial, as well as the total number of visits recommended if there is evidence of functional improvement. The request for Psychologist Cognitive Behavioral Therapy - 12 Sessions is determined to not be medically necessary.

Sleep Evaluation: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pain chapter, Polysomnography section

Decision rationale: The MTUS Guidelines do not address the use of sleep evaluation. The ODG recommends the use of polysomnogram after at least six months of an insomnia complaint (at least four nights a week), unresponsive to behavior intervention and sedative/sleep-promoting medications, and after psychiatric etiology has been excluded. Other indications include excessive daytime somnolence, cataplexy, morning headache (other causes have been ruled out), intellectual deterioration, personality change, sleep-related breathing disorder or periodic limb movement disorder is suspected. There is no indication that behavior intervention and sedative/sleep-promoting medications have been utilized, and that psychiatric etiology has been excluded. The request for Sleep Evaluation is determined to not be medically necessary.

TENS Unit: 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 Transcutaneous Electrotherapy section Page(s): 114-116.

Decision rationale: The use of TENS for chronic pain is not recommended by the MTUS Guidelines as a primary treatment modality, but a one-month home-based TENS trial may be considered if used as an adjunct to a program of evidence-based functional restoration in certain conditions. A home based treatment trial of one month may be appropriate for neuropathic pain and CRPS II and for CRPS I. There is some evidence for use with neuropathic pain, including diabetic neuropathy and post-herpetic neuralgia. There is some evidence to support use with phantom limb pain. TENS may be a supplement to medical treatment in the management of spasticity in spinal cord injury. It may be useful in treating MS patients with pain and muscle spasm. The criteria for use of TENS include chronic intractable pain (for one of the conditions noted above) with documentation of pain of at least three months duration, evidence that other

appropriate pain modalities have been tried (including medication) and failed, a one month trial period of 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, and a treatment plan including specific short and long term goals of treatment. The requesting physician did not provide a rationale for this request, or address the criteria for use as listed in the MTUS Guidelines. Medical necessity for this request has not been established. The request for TENS Unit is determined to not be medically necessary.