

Case Number:	CM14-0159271		
Date Assigned:	10/02/2014	Date of Injury:	09/29/2013
Decision Date:	12/31/2014	UR Denial Date:	09/11/2014
Priority:	Standard	Application Received:	09/29/2014

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 Preventative Medicine, has a subspecialty in Occupational Medicine and is licensed to practice in Iowa. 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:

This patient is a 50 year old employee with date of injury of 9/29/2013. Medical records indicate the patient is undergoing treatment for s/p anterior lumbar interbody fusion at L5-S1; anterior cervical discectomy; partial vertibrectomy for spinal cord decompression and total disc replacement at C4-C5 with ProDisc C implant. He has multilevel degenerative disc disease (DDD) of the cervical spine with spinal stenosis and radiculopathy. Subjective complaints include low back pain which radiates bilaterally to distal calves. The pain is described as burning, sharp, and throbbing and pressure like pain. Pain ranges from a 4-10/10 in intensity. He has had periods of urinary incontinence. Pain is aggravated by lifting, carrying and twisting. He has trouble sleeping and is suffering from severe insomnia. He currently reports his neck as "stiff" and has mild intermittent aching in the pain. Sometimes the pain radiates to the right trapezial region and shoulder. If he holds his arms at shoulder level, he experiences numbness. Aggravating factors include turning his head and general movement of the neck. Objective findings include normal gait and heel to toe walk. Spurling's maneuver produces some slight axial discomfort but no radicular symptoms. On the thoracolumbar spine, there is no increase in his constant underlying back pain with palpation. The cervical spine exam produces some mild muscle guarding by no asymmetric loss of motion. There is no fixed muscle spasm noted. His reflexes are 2+ and symmetric at biceps and brachioradialis; 1+ and symmetric at the triceps; 1+ and symmetric at patellar and 2+ symmetric at the Achilles bilaterally. Babinski is downward bilaterally. Hoffman's sign is negative bilaterally. A prior physician consultation (11/26/12) noted that the patient received 2 epidural injections and that the injections only gave the patient relief for a week or so. Treatment has consisted of the following; physical therapy (PT), transcutaneous electrical nerve stimulator (TENS), and epidural steroid injection (ESI) at L4-5, OxyContin, Norco, Neurontin, and Klonopin, Testosterone cream HCG, DHEA, Anastosol,

Finasteride and Lexapro. The utilization review determination was rendered on 9/11/2014 recommending non-certification of Physical therapy for the cervical spine and lumbar spine, TENS (Transcutaneous Electrical Nerve Stimulation) unit, Lumbar ESI (Epidural Steroid Injection) at L4-5 and Acupuncture.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy for the cervical spine and lumbar spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 65-194, Chronic Pain Treatment Guidelines Physical Therapy, Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Low Back - Lumbar & Thoracic (Acute & Chronic), Physical Therapy, ODG Preface - Physical Therapy.

Decision rationale: California MTUS guidelines refer to physical medicine guidelines for physical therapy and recommends as follows: "Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." Additionally, ACOEM guidelines advise against passive modalities by a therapist unless exercises are to be carried out at home by patient. ODG quantifies its recommendations with 10 visits over 8 weeks for lumbar sprains/strains and 9 visits over 8 weeks for unspecified backache/lumbago. Regarding physical therapy, ODG states "Patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy); & (6) When treatment duration and/or number of visits exceeds the guideline, exceptional factors should be noted." The patient has 12 previous PT sessions, which is in excess of guidelines. Also, there is no documentation to support that there was failure of a home exercise program and the treating physician did not detail exceptional factors to exceed guideline recommendations. . As such, the request for Physical therapy for the cervical spine and lumbar spine is not medically necessary.

Acupuncture: Overturned

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

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Low Back - Lumbar & Thoracic (Acute & Chronic), Acupuncture

Decision rationale: MTUS "Acupuncture Medical Treatment Guidelines" clearly state that "acupuncture is used as an option when pain medication is reduced or not tolerated; it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional

recovery." ODG does not recommend acupuncture for acute low back pain, but "may want to consider a trial of acupuncture for acute LBP if it would facilitate participation in active rehab efforts." The initial trial should "3-4 visits over 2 weeks with evidence of objective functional improvement, total of up to 8-12 visits over 4-6 weeks (Note: The evidence is inconclusive for repeating this procedure beyond an initial short course of therapy.)" There is no evidence provided that indicates the patient received acupuncture before. Acupuncture sessions are being used as an adjunct to physical rehabilitation. I concur with the utilization reviewer that acupuncture is medically necessary. As such, the request for acupuncture is medically necessary.

TENS (transcutaneous electrical nerve stimulation) unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS (Transcutaneous Electrical Nerve Stimulation)..

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation, Transcutaneous Electrotherapy Page(s): 54, 114-116, 118-120. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Pain, TENS Chronic Pain (Transcutaneous Electrical Nerve Stimulation).

Decision rationale: MTUS states regarding TENS unit, "Not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration, for the conditions described below." For pain, MTUS and ODG recommend TENS (with caveats) for neuropathic pain, phantom limb pain and CRPSII, spasticity, and multiple sclerosis. The medical records do not indicate any of the previous conditions. ODG further outlines recommendations for specific body parts: Low back: Not recommended as an isolated intervention. Knee is recommended as an option for osteoarthritis as adjunct treatment to a therapeutic exercise program. Neck is not recommended as a primary treatment modality for use in whiplash-associated disorders, acute mechanical neck disease or chronic neck disorders with radicular findings. Ankle and foot is not recommended. Elbow is not recommended. Forearm, Wrist and Hand is not recommended. Shoulder is recommended for post-stroke rehabilitation. ODG further details criteria for the use of TENS for Chronic intractable pain (for the conditions noted above): (1) Documentation of pain of at least three months duration (2) There is evidence that other appropriate pain modalities have been tried (including medication) and failed. (3) 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; rental would be preferred over purchase during this trial. (4) Other ongoing pain treatment should also be documented during the trial period including medication usage. (5) A treatment plan including the specific short- and long-term goals of treatment with the TENS unit should be submitted. (6) After a successful 1-month trial, continued TENS treatment may be recommended if the physician documents that the patient is likely to derive significant therapeutic benefit from continuous use of the unit over a long period of time. At this point purchase would be preferred over rental. (7) Use for acute pain (less than three months duration) other than post-operative pain is not recommended. (8) A 2-lead unit is generally recommended; if a 4-lead unit is recommended, there must be documentation of why this is necessary. The medical records do not

satisfy several of the criteria to include failure of conservative treatment modalities. The patient is currently undergoing a trial of acupuncture therapy and the outcome of that therapy is unknown at this time. In addition, the treating physician did not document short-term treatment goals with TENS unit. As such, the request for TENS (transcutaneous electrical nerve stimulation) unit is not medically necessary.

Lumbar ESI (epidural steroid injection) at L4-5: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs)..

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315, Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs), Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Low Back - Lumbar & Thoracic (Acute & Chronic), Epidural steroid injections (ESIs), Therapeutic.

Decision rationale: MTUS Chronic pain medical treatment guidelines state that epidural steroid injections are "Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) . . . Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program." No objective findings were documented to specify the dermatomal distribution of pain. MTUS further defines the criteria for epidural steroid injections to include: 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). 3) Injections should be performed using fluoroscopy (live x-ray) for guidance. 4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections. 5) No more than two nerve root levels should be injected using transforaminal blocks. 6) No more than one interlaminar level should be injected at one session. 7) In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007) 8) Current researches do not support a "series-of-three" injection in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections. The treating physician did not provide current documentation that specified a specific radiculopathy, focal neurologic deficits, and no documentation of corroborating medical imaging or electrodiagnostic studies. As such, the request for Lumbar ESI (epidural steroid injection) at L4-5 is not medically necessary.