

Case Number:	CM14-0162621		
Date Assigned:	10/27/2014	Date of Injury:	04/25/2011
Decision Date:	12/10/2014	UR Denial Date:	09/15/2014
Priority:	Standard	Application Received:	10/03/2014

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:

According to the records made available for review, this is a 46-year-old female with a 4/25/11 date of injury. At the time (9/11/14) of the decision for lumbar back support and back support insert purchase, hot and cold wrap purchase, neoprene multi-position plus and joint addition polycentric purchase, TENS unit purchase, trigger point injections pelvic region, trigger point injections to the thigh, MRI without contrast for the left hip, MRI without contrast for the left knee, 12 sessions physical therapy to the lumbar area, and injections to the left hip and left knee, there is documentation of subjective (low back pain with motion loss, stiffness, weather effects, spasm; and pain traveling down the left leg with numbness and weakness) and objective (antalgic gait, decreased range of motion, tenderness along the lumbosacral area and SI joints bilaterally, absent deep tendon reflexes of the knees, increased sensory function on the right, generalized weakness of the left lower extremity, and decreased hip range of motion) findings. The current diagnoses are localized lumbar degenerative disc disease with left sided radicular symptoms and left SI joint strain. The treatment to date includes medications. Regarding lumbar back support and back support insert purchase; there is no documentation of compression fractures, spondylolisthesis, or documented instability. Regarding neoprene multi-position plus and joint addition polycentric purchase, there is no documentation of patellar instability, anterior cruciate ligament (ACL) tear, or medical collateral ligament (MCL) instability; that the patient is going to be stressing the knee under load; or abnormal limb contour (valgus [knock-kneed] limb, varus [bow-legged] limb, tibial varum, disproportionate thigh and calf (e.g., large thigh and small calf), or minimal muscle mass on which to suspend a brace); skin changes (such as: excessive redundant soft skin, thin skin with risk of breakdown (e.g., chronic steroid use), severe osteoarthritis (grade III or IV), maximal off-loading of painful or repaired knee compartment (example: heavy patient; significant pain), or severe instability as noted on physical examination

of knee). Regarding the TENS unit purchase, there is no documentation that the TENS unit will be used as an adjunct to a program of evidence-based functional restoration and a treatment plan including the specific short- and long-term goals of treatment with the TENS. Regarding trigger point injections pelvic region and trigger point injections to the thigh, there is no documentation of myofascial pain syndrome; circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain; additional medical management therapies (ongoing stretching exercises and physical therapy) have failed to control pain; radiculopathy is not present (by exam); and no more than 3-4 injections per session. Regarding MRI without contrast for the left hip, there is no documentation of negative plain radiographs and a high suspicion for occult fracture; osseous, articular or soft tissue abnormalities; osteonecrosis; occult acute and stress fractures; acute and chronic soft tissue injuries; or tumors. Regarding MRI without contrast for the left knee, there is no documentation of a condition/diagnosis (with supportive subjective/objective findings) for which an MRI of the knee is indicated. Regarding 12 sessions physical therapy to the lumbar area, it cannot be determined if this is a request for initial or additional physical therapy. Regarding injections to the left hip and left knee, there is no documentation of moderately advanced or severe hip osteoarthritis or as short term pain relief in hip trochanteric bursitis and that injection will be in conjunction with fluoroscopic guidance; and symptomatic severe osteoarthritis of the knee, which requires knee pain which interferes with functional activities not attributed to other forms of joint disease, and that the additional criteria for injection have been met.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar back support and back support insert purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Lumbar Support

Decision rationale: MTUS reference to ACOEM identifies that lumbar support have not been shown to have any lasting benefit beyond acute phase of symptom relief. Official Disability Guidelines identifies documentation of compression fractures, spondylolisthesis, or documented instability, as criteria necessary to support the medical necessity of lumbar support. Within the medical information available for review, there is documentation of diagnoses of localized lumbar degenerative disc disease with left sided radicular symptoms and left SI joint strain. However, there is no documentation of compression fractures, spondylolisthesis, or documented instability. Therefore, based on guidelines and a review of the evidence, the request for lumbar back support and back support insert purchase is not medically necessary.

Hot and cold wrap purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Cold/heat packs; Other Medical Treatment Guideline or Medical Evidence: PMID: 18214217 PubMed - indexed for MEDLINE

Decision rationale: MTUS reference to ACOEM guidelines identifies at-home applications of local heat or cold to the low back as an optional clinical measure for evaluation and management of low back complaints. Official Disability Guidelines identifies that there is minimal evidence supporting the use of cold therapy. Medical Treatment Guideline identifies that exact recommendations on application on time and temperature cannot be given. Therefore, based on guidelines and a review of the evidence, the request for hot and cold wrap purchase is not medically necessary.

Neoprene multi-position plus and joint addition polycentric purchase: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 340. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, Knee braces

Decision rationale: MTUS reference to ACOEM Guidelines identifies that a brace can be used for patellar instability, anterior cruciate ligament (ACL) tear, or medical collateral ligament (MCL) instability; and that a brace is necessary only if the patient is going to be stressing the knee under load. Official Disability Guidelines identifies documentation of abnormal limb contour (such as: Valgus [knock-kneed] limb, Varus [bow-legged] limb, Tibial varum, Disproportionate thigh and calf (e.g., large thigh and small calf), or Minimal muscle mass on which to suspend a brace); Skin changes (such as: Excessive redundant soft skin, Thin skin with risk of breakdown (e.g., chronic steroid use), Severe osteoarthritis (grade III or IV), Maximal off-loading of painful or repaired knee compartment (example: heavy patient; significant pain), or Severe instability as noted on physical examination of knee), as additional criteria necessary to support the medical necessity of knee braces. Within the medical information available for review, there is documentation of diagnoses of localized lumbar degenerative disc disease with left sided radicular symptoms and left SI joint strain. However, there is no documentation of patellar instability, anterior cruciate ligament (ACL) tear, or medical collateral ligament (MCL) instability; that the patient is going to be stressing the knee under load; or abnormal limb contour (Valgus [knock-kneed] limb, Varus [bow-legged] limb, Tibial varum, Disproportionate thigh and calf (e.g., large thigh and small calf), or Minimal muscle mass on which to suspend a brace); Skin changes (such as: Excessive redundant soft skin, Thin skin with risk of breakdown (e.g., chronic steroid use), Severe osteoarthritis (grade III or IV), Maximal off-loading of painful or repaired knee compartment (example: heavy patient; significant pain), or Severe instability as noted on physical examination of knee). Therefore, based on guidelines and a review of the evidence, the request for Neoprene multi-position plus and joint addition polycentric purchase is not medically necessary.

TENS unit purchase: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrical nerve stimulation (TENS) Page(s): 113-117.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of pain of at least three months duration, evidence that other appropriate pain modalities have been tried (including medication) and failed, a statement identifying that the TENS unit will be used as an adjunct to a program of evidence-based functional restoration, and a treatment plan including the specific short- and long-term goals of treatment with the TENS, as criteria necessary to support the medical necessity of a month trial of a TENS unit. In addition, MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of how often the unit was used, outcomes in terms of pain relief and function, and other ongoing pain treatment during the trial period (including medication use), as criteria necessary to support the medical necessity of continued TENS unit. Within the medical information available for review, there is documentation of diagnoses of localized lumbar degenerative disc disease with left sided radicular symptoms and left SI joint strain. In addition, there is documentation of pain of at least three months duration and evidence that other appropriate pain modalities have been tried (including medication) and failed. However, there is no documentation that the TENS unit will be used as an adjunct to a program of evidence-based functional restoration and a treatment plan including the specific short- and long-term goals of treatment with the TENS. In addition, the requested TENS unit purchase exceeds guidelines (for an initial one month trial). Therefore, based on guidelines and a review of the evidence, the request for TENS unit purchase is not medically necessary.

Trigger point injections pelvic region: Upheld

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

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

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of myofascial pain syndrome; circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain; symptoms have persisted for more than three months; medical management therapies such as ongoing stretching exercises, physical therapy, NSAIDs and muscle relaxants have failed to control pain; radiculopathy is not present (by exam, imaging, or neuro-testing); and no more than 3-4 injections per session, as criteria necessary to support the medical necessity of trigger point injections. Additionally MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of greater than 50% pain relief is obtained for six weeks after an injection, documented evidence of functional improvement, and injections not at an interval less than two months, as criteria necessary to support the medical necessity of repeat trigger point injections. Within the medical information

available for review, there is documentation of diagnoses of localized lumbar degenerative disc disease with left sided radicular symptoms and left SI joint strain. In addition, there is documentation that symptoms have persisted for more than three months; and that medical management therapies (medications) have failed to control pain. However, there is no documentation of myofascial pain syndrome; circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain; additional medical management therapies (ongoing stretching exercises and physical therapy) have failed to control pain; and no more than 3-4 injections per session. In addition, given documentation of a diagnosis of localized lumbar degenerative disc disease with left sided radicular symptoms (with supportive subjective/objective findings), there is no documentation that radiculopathy is not present (by exam). Therefore, based on guidelines and a review of the evidence, the request for trigger point injections pelvic region is not medically necessary.

Trigger point injections to the thigh: Upheld

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

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

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of myofascial pain syndrome; circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain; symptoms have persisted for more than three months; medical management therapies such as ongoing stretching exercises, physical therapy, NSAIDs and muscle relaxants have failed to control pain; radiculopathy is not present (by exam, imaging, or neuro-testing); and no more than 3-4 injections per session, as criteria necessary to support the medical necessity of trigger point injections. Additionally MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of greater than 50% pain relief is obtained for six weeks after an injection, documented evidence of functional improvement, and injections not at an interval less than two months, as criteria necessary to support the medical necessity of repeat trigger point injections. Within the medical information available for review, there is documentation of diagnoses of localized lumbar degenerative disc disease with left sided radicular symptoms and left SI joint strain. In addition, there is documentation that symptoms have persisted for more than three months; and that medical management therapies (medications) have failed to control pain. However, there is no documentation of myofascial pain syndrome; circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain; additional medical management therapies (ongoing stretching exercises and physical therapy) have failed to control pain; and no more than 3-4 injections per session. In addition, given documentation of a diagnosis of localized lumbar degenerative disc disease with left sided radicular symptoms (with supportive subjective/objective findings), there is no documentation that radiculopathy is not present (by exam). Therefore, based on guidelines and a review of the evidence, the request for trigger point injections to the thigh is not medically necessary.

MRI without contrast for the left hip: 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: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip & Pelvis, MRI (magnetic resonance imaging)

Decision rationale: MTUS does not address this issue. Official Disability Guidelines identifies documentation of negative plain radiographs and a high suspicion for occult fracture; osseous, articular or soft tissue abnormalities; osteonecrosis; occult acute and stress fractures; acute and chronic soft tissue injuries; or tumors as criteria necessary to support the medical necessity of MRI of the hip/pelvis. Within the medical information available for review, there is documentation of diagnoses of localized lumbar degenerative disc disease with left sided radicular symptoms and left SI joint strain. However, there is no documentation of negative plain radiographs and a high suspicion for occult fracture; osseous, articular or soft tissue abnormalities; osteonecrosis; occult acute and stress fractures; acute and chronic soft tissue injuries; or tumors. Therefore, based on guidelines and a review of the evidence, the request for MRI without contrast for the left hip is not medically necessary.

MRI without contrast for the left knee: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 344-352. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee, Magnetic resonance imaging (MRI)

Decision rationale: MTUS reference to ACOEM identifies documentation of an unstable knee with documented episodes of locking, popping, giving way, recurrent effusion, or clear signs of a bucket handle tear, as well as non-diagnostic radiographs, as criteria necessary to support the medical necessity of MRI of the knee (first 30 days). Official Disability Guidelines identifies documentation of a condition/diagnosis (with supportive subjective/objective findings) for which an MRI of the knee is indicated (such as: acute trauma to the knee, including significant trauma, or if suspect posterior knee dislocation or ligament or cartilage disruption; Non-traumatic knee pain; initial anteroposterior and lateral radiographs non-diagnostic; patellofemoral (anterior) symptoms; initial anteroposterior, lateral, and axial radiographs non-diagnostic; non-trauma, non-tumor, non-localized pain; or initial anteroposterior and lateral radiographs demonstrate evidence of internal derangement), as criteria necessary to support the medical necessity of MRI of the knee (after 30 days). Within the medical information available for review, there is documentation of diagnoses of localized lumbar degenerative disc disease with left sided radicular symptoms and left SI joint strain. However, there is no documentation of a condition/diagnosis (with supportive subjective/objective findings) for which an MRI of the knee is indicated. Therefore, based on guidelines and a review of the evidence, the request for MRI without contrast for the left knee is not medically necessary.

12 sessions physical therapy to the lumbar area: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Physical Therapy (PT); Other Medical Treatment Guideline or Medical Evidence: Title 8, California Code of Regulations, section 9792.20

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines support a brief course of physical medicine for patients with chronic pain not to exceed 10 visits over 4-8 weeks with allowance for fading of treatment frequency, with transition to an active self-directed program of independent home physical medicine/therapeutic exercise. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Official Disability Guidelines recommends a limited course of physical therapy for patients with a diagnosis of radiculitis not to exceed 12 visits over 8 weeks. Official Disability Guidelines also notes 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) and when treatment requests exceeds guideline recommendations, the physician must provide a statement of exceptional factors to justify going outside of guideline parameters. Within the medical information available for review, there is documentation of diagnoses of localized lumbar degenerative disc disease with left sided radicular symptoms and left SI joint strain. However, given documentation of a 4/25/11 date of injury, where there would have been an opportunity to have had previous physical therapy, it is not clear if this is a request for initial or additional (where physical therapy provided to date may have already exceeded guidelines regarding a time-limited plan and there is the necessity of documenting functional improvement) physical therapy. Therefore, based on guidelines and a review of the evidence, the request for 12 sessions of physical therapy to the lumbar area is not medically necessary.

Injections to the left hip and left knee: 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: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip & Pelvis and Knee, Intra-articular steroid hip injection (IASHI); and Corticosteroid injections

Decision rationale: MTUS does not address the issue. Specifically regarding the hip, Official Disability Guidelines identifies documentation of moderately advanced or severe hip osteoarthritis or as short term pain relief in hip trochanteric bursitis, as criteria necessary to support the medical necessity of intra-articular steroid hip injection. In addition, Official Disability Guidelines additionally identifies that injection should be used in conjunction with

fluoroscopic guidance. Specifically regarding the knee, Official Disability Guidelines identifies documentation of symptomatic severe osteoarthritis of the knee, which requires knee pain which interferes with functional activities (e.g., ambulation, prolonged standing) and not attributed to other forms of joint disease, and at least 5 of the following: (Bony enlargement; Bony tenderness; Crepitus (noisy, grating sound) on active motion; Erythrocyte sedimentation rate (ESR) less than 40 mm/hr; Less than 30 minutes of morning stiffness; No palpable warmth of synovium; Over 50 years of age; Rheumatoid factor less than 1:40 titer (agglutination method); and/or Synovial fluid signs (clear fluid of normal viscosity and WBC less than 2000/mm³)); failure of conservative treatment (exercise, NSAIDs or acetaminophen); Only one injection should be scheduled to start, rather than a series of three; A second injection is not recommended if the first has resulted in complete resolution of symptoms, or if there has been no response; and The number of injections should be limited to three, as criteria necessary to support the medical necessity of corticosteroid injections to the knee. Within the medical information available for review, there is documentation of diagnoses of localized lumbar degenerative disc disease with left sided radicular symptoms and left SI joint strain. However, there is no documentation of moderately advanced or severe hip osteoarthritis or as short term pain relief in hip trochanteric bursitis and that injection will be in conjunction with fluoroscopic guidance. In addition, there is no documentation of symptomatic severe osteoarthritis of the knee, which requires knee pain which interferes with functional activities not attributed to other forms of joint disease, and that the additional criteria for injection have been met. Therefore, based on guidelines and a review of the evidence, the request for injections to the left hip and left knee is not medically necessary.