

Case Number:	CM14-0032845		
Date Assigned:	06/20/2014	Date of Injury:	01/31/2014
Decision Date:	08/29/2014	UR Denial Date:	03/04/2014
Priority:	Standard	Application Received:	03/14/2014

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 Physical Medicine and Rehabilitation and is licensed to practice in Texas. 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 57-year-old male sustained an industrial injury on 1/31/2014. The patient indicates he developed lower back pain due to cumulative trauma during the course of his employment as a mechanic 1/31/2013-1/31/2014. The prior UR determination was provided on 3/4/2014, wherein recommendation is to modify the request for PT to the lumbar spine times, 6/10 sessions. Noncertification was rendered for all of the requests, as the medical necessity is not established. According to the 1st Doctors Report dated 2/14/2014, the patient complained of back pain and pain in both lower extremities. Physical examination of the lumbosacral spine documented tenderness to palpation of the bilateral paraspinal muscles, SI joint, sciatic notch/posterior iliac crest/gluteal muscles, as well as spasms and trigger points, decreased range of motion, and positive straight leg raise straight leg raising test right at 45. Diagnosis lumbosacral musculoligamentous strain/sprain with radiculitis; rule out lumbosacral spine discogenic disease. The patient was given prescriptions for topical medications, tramadol, interferential unit, and hot-cold unit, request was made for lumbar MRI, EMG/NCV of the bilateral lower extremities, and referral to physical therapy for the lumbar spine 2 times a week for 6 weeks. The patient was placed on TTD. According to the progress report dated 3/26/2014, the patient presented for follow-up regarding complaints of lower back pain that radiates to the bilateral L5-S1 dermatomes. Lower back pain is rated 8-9/10, which has increased from 7/10 on the last visit. Examination of lumbar spine documents, 2-3 tenderness to palpation over the paraspinal muscles, restricted range of motion, and bilaterally. Positive straight leg raise, right greater than left. There are no changes to the neurological and circulatory examination. The patient indicates physical therapy helps decrease his pain and tenderness, he is experiencing persistent pain in the bilateral lower extremities, right greater than left. The patient has processed physiotherapy, and is to continue. The patient presented the patient was in for follow-up

evaluation on 5/7/2014 regarding lower back pain, which he rated 7/10. On examination of lumbar spine, there is grade 3 tenderness to palpation of the paraspinal muscles, restricted range of motion, and positive straight leg test bilaterally. There are no changes on the neurological and circulatory examination. The patient states treatment helps, indicates his function and activities of daily living have improved by 10%.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Low back, MRIs (magnetic resonance imaging).

Decision rationale: According to the CA MTUS/ACOEM guidelines, the criteria for ordering imaging studies are: Emergence of a red flag; Physiologic evidence of tissue insult or neurologic dysfunction; Failure to progress in a strengthening program intended to avoid surgery; and Clarification of the anatomy prior to an invasive procedure. In the case of this patient, the medical records do not provide any evidence of neurological dysfunction or failure to progress with conservative care. The patient is not pending any surgical intervention. In the absence of any progressive neurological deficit, a lumbar spine MRI is not medically indicated.

Electromyogram (EMG) of the bilateral lower extremities: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, EMGs (electromyography).

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

Decision rationale: According to the guidelines, following a course of conservative therapy, an EMG study may be useful to obtain unequivocal evidence of radiculopathy. However, the patient indicates he has improved with PT to date. More importantly, the examinations on 2/14/2014, 3/26/2014 and 5/7/2014 do not provide any clear indication of any focal neurological deficit. The medical records do not appear to document objective clinical findings that would suggest active radiculopathy is present. The medical records do not provide any clinical evidence that would support the potential diagnosis of lumbar radiculopathy. There are no neurological deficits revealed on objective examination. An EMG study is not medically indicated.

Nerve conduction velocity (NCV) study of the bilateral lower extremities: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, 2nd Edition, Update to Chapter 12, Low Back Disorders.

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, Nerve Conduction Studies (NCS).

Decision rationale: The CA MTUS/ACOEM and Official Disability Guidelines suggest EMG may be useful for evaluation of subtle focal neurologic dysfunction in patients with low back symptoms, not NCV. According to the guidelines, there is minimal justification for performing nerve conduction studies when a patient is presumed to have symptoms on the basis of radiculopathy. Furthermore, the patient's examination revealed no motor strength, sensation, or reflexes changes throughout the bilateral lower extremities. The medical necessity of an NCV of the lower extremities has not been established.

Interferential (IF) Stimulator unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS), page(s) 118-119 Page(s): 118-119.

Decision rationale: According to the ACOEM guidelines, insufficient evidence exists to determine the effectiveness of sympathetic therapy, a noninvasive treatment involving electrical stimulation, also known as interferential therapy. The medical records do not establish the patient has failed standard treatment measures. According to the CA MTUS guidelines, interferential current stimulation is not generally recommended as there is no evidence supporting or establishing efficacy in this form of treatment. The medical records do not establish this patient has any of the criteria such as history of substance abuse or significant postoperative pain, or ineffective pain control with medications due to significant side effects. The medical do not establish that purchase of the requested IF unit is appropriate or medically necessary for the management of this patient's diagnosis.

Hot and Cold unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Practice Guidelines, 3rd Edition, Low Back Disorders Chapter (Update to Chapter 12).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 44. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Cold/heat packs; Continuous-flow cryotherapy, Heat therapy.

Decision rationale: According to the CA MTUS/ACOEM and Official Disability Guidelines, heat and cold packs are recommended as an option for pain. At-home local applications of cold packs in first few days of acute complaint; thereafter, applications of heat packs or cold packs. There is inadequate clinical evidence to substantiate that a hot/cold unit is more efficacious than standard ice/cold and hot packs. The references state mechanical circulating units with pumps have not been proven to be more effective than passive hot and cold therapy. Simple at home applications of heat and cold will suffice for delivery of heat or cold therapy. The medical necessity of a hot-cold unit is not established.

Prescription of Fluriflex 180gm: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47.

Decision rationale: According to ACOEM guidelines, topical medications are not recommended. Fluriflex is a topical compound containing Flurbiprofen and Cyclobenzaprine. The guidelines state oral pharmaceuticals are a first-line palliative method. Nonprescription analgesics provide sufficient pain relief for most patients with acute work-related symptoms. The guidelines state that muscle relaxants seem no more effective than NSAIDs for treating patients with musculoskeletal problems, and using them in combination with NSAIDs has no demonstrated benefit. The medical records do not demonstrate this patient is unable to tolerate standard oral analgesics. The medical necessity of topical compound agents is not established in this case.

Prescription of TGHot 180gm: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

Decision rationale: According to the MTUS guidelines, topical medications are not recommended. The guidelines state oral pharmaceuticals are a first-line palliative method. Nonprescription analgesics provide sufficient pain relief for most patients with acute work-related symptoms. The medical records do not demonstrate this patient is unable to tolerate standard oral analgesics. Therefore, the request for a prescription of TGHot 180 gm is not medically necessary and appropriate.

Prescription of Tramadol 50mg #60: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment Page(s): 47-48.

Decision rationale: According to the guidelines, opioids appear to be no more effective than safer analgesics for managing most musculoskeletal and eye symptoms; they should be used only if needed for severe pain and only for a short time. Opioids cause significant side effects, including poor patient tolerance, constipation, drowsiness, clouded judgment, memory loss, and potential misuse or dependence have been reported in up to 35% of patients. The guidelines state relieving discomfort of low back complaints can be accomplished most safely by nonprescription medication or an appropriately selected nonsteroidal anti-inflammatory drug (NSAID), appropriate adjustment of activity, and use of thermal modalities such as ice and/or heat. The patient's pain complaints can be adequately addressed with standard oral analgesics, access to opioid is not medically supported.

Physical therapy evaluation and treatment for the lumbar spine; two times a week for six weeks (2x6): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy. Decision based on Non-MTUS Citation Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

Decision rationale: MTUS guidelines recommend low-stress aerobic activities can be safely started after the first two weeks of symptoms to help avoid debilitation. Careful stretching exercises within the normal range of motion may be helpful to avoid further restriction of motion. Exercises to strengthen low back and abdominals should be initiated and early stage lumbar stabilization exercises can be used without aggravation of symptoms. The medical literature strongly supports the initiation of therapy to help alleviate symptoms and return the patient to normal activities. According to the Official Disability Guidelines, 10 physical therapy sessions are recommended for the patient's diagnosis, which should allow for fading of treatment, plus active self-directed home physical therapy. Therefore, the request for physical therapy evaluation and treatment for the lumbar spine; twice a week for six weeks is not medically necessary and appropriate.