MAXIMUS Federal Services

| Case Number: | CM14-0054100 | | |
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| Date Assigned: | 08/08/2014 | Date of Injury: | 03/10/2012 |
| Decision Date: | 09/15/2014 | UR Denial Date: | 03/28/2014 |
| Priority: | Standard | Application Received: | 04/23/2014 |

## 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 & Rehabilitation and is licensed to practice in Nevada. 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 injured worker is a 38-year-old male who was reportedly injured on March 10, 2012. The mechanism of injury was noted as "altercation was suspect" during the performance of his duties as a peace officer. The most recent progress note February 26, 2014, indicated that there were ongoing complaints of low back pain. Additional sacroiliac joint injections were noted as well as mental health issues requiring psychotherapy. It was noted that the injured employee has reached a permanent and stationary status. The physical examination demonstrated a hypertensive (130/99) individual who was noted to be slightly depressed, and a slow gait pattern was reported. A decrease in lumbar spine range of motion was noted and straight leg raise was reported to be positive. Diagnostic imaging studies objectified a moderate spinal stenosis. Previous treatment included injection therapy, chiropractic care, physical therapy, multiple medications and pain management interventions. A request had been made for a transcutaneous electrical nerve stimulation unit, sacroiliac joint injections, and multiple medications and was not certified in the pre-authorization process on March 28, 2014.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Chiropractic physical therapy eight visits (8) 2 x 4:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 58-59.

**Decision rationale:** When noting the date of injury, the mechanism of injury the findings noted on enhanced imaging studies and by the parameters outlined in the California Medical Treatment Utilization Schedule, this is not medically necessary. As outlined in the California Medical Treatment Utilization Schedule, there is support for radiotherapy; however, there are limitations relative to the number of visits and the timeframe for which the intervention is indicated. When noting the findings on physical examination, and the changes identified on magnetic resonance image, there is no clinical indication or medical necessity presented to support this request. Therefore the request is not medically necessary.

**TENS trial one (10 month:** 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 Page(s): 113-116.

**Decision rationale:** Not recommended as a primary treatment modality, but a one-month home-based transcutaneous electrical nerve stimulation trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration. However, this device has been employed for a significant period of time and the progress notes presented for review do not indicate any efficacy or utility. There is no increased functionality, decrease in symptomatology or other parameter by which it is noted that this has having any positive affect. Therefore the request is not medically necessary.

**Sacroiliac joint injection:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Hip and Pelvis Chapter, Sacroiliac joint blocks.

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

**Decision rationale:** The California Medical Treatment Utilization Schedule/American College of Occupational and Environmental Medicine practice guidelines do not support sacroiliac (SI) joint injections for acute, sub-acute, or chronic low back pain. The only clinical indication for a SI joint injection is for therapeutic treatment for rheumatologic inflammatory arthritis involving the sacroiliac joints. Review, of the available medical records, fails to provide any documentation of a diagnosis of rheumatoid arthritis with SI joint arthritis. As such, the request is not medically necessary.

**Buspar 10 mg BID prn #30:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation http://www.ncbi.nim.nih.gov/pubmedhealth/PMHTO009364/?report=details.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Pain chapter updated August 2014.

**Decision rationale:** It is noted that this medication is not addressed in the California Medical Treatment Utilization Schedule or American College of Occupational and Environmental Medicine guidelines. The parameters noted in the Official Disability Guidelines were employed. This is an antianxiety medication. However, the most recent progress notes do not address the efficacy or utility of this preparation in terms of decreased symptomatology. As such, there is insufficient clinical information presented to establish the medical necessity of this medication. Therefore the request is not medically necessary.

**Norco 10/325 mg tid as needed for pain:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 88.

**Decision rationale:** Norco (hydrocodone/acetaminophen) is a short acting opiate indicated for the management of moderate to severe breakthrough pain. The California Medical Treatment Utilization Schedule guidelines support short-acting opiates at the lowest possible dose to improve pain and function, as well as the ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects. The injured employee has chronic pain; however, there is no objective clinical documentation of improvement in the pain or function with the current regimen. As such, the request for Norco is not medically necessary.

**Epidural Injection:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

**Decision rationale:** The Epidural steroid injections are recommended as an option for the treatment of radicular pain. While noting there is a spinal stenosis identified on magnetic resonance image, there is no objectification on electrodiagnostic assessment of a verifiable radiculopathy. Furthermore, the findings noted on physical examination did not corroborate that there is evidence of a verifiable radiculopathy. As such, when noting the parameters outlined in

the California Medical Treatment Utilization Schedule and by the physical examination reported, therefore this request is not medically necessary.