

Case Number:	CM14-0056024		
Date Assigned:	09/12/2014	Date of Injury:	02/18/2014
Decision Date:	10/14/2014	UR Denial Date:	03/25/2014
Priority:	Standard	Application Received:	04/25/2014

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 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:

The injured worker is a 56-year-old male who reported an injury on 02/18/2014 due to constantly bending over in a sewing factory, he started to develop neck and back pain. Diagnoses were cervical musculoligamentous injury, cervical muscle spasm, rule out cervical radiculitis versus radiculopathy, lumbosacral sprain/strain, lumbar muscle spasm, sprain SI joint left, chest contusion, anterolisthesis of the L5-S1 (5 mm) with spina bifida per x-ray, and rule out lumbar disc protrusion. Past treatments were physical therapy and chiropractic sessions. The diagnostic studies were an MRI of the cervical spine that revealed a 1 to 2 mm posterior disc bulge at the C3-T1 without evidence of canal stenosis of neural foraminal narrowing, nonspecific straightening of the normal cervical lordosis, and query strain. There was a lumbar spine x-ray. Surgical history was not reported. Physical examination on 07/09/2014 revealed complaints of constant and moderate neck pain, numbness, and tingling. The pain was rated a 7/10. The examination revealed sensation was decreased globally in the left upper extremity. Motor strength was 5/5 bilaterally in the upper and lower extremities. Deep tendon reflexes were normal and equal bilaterally at 2/2. The cervical range of motion was decreased and painful. There was +3 tenderness to palpation of the cervical paravertebral muscles. There were muscle spasms of the cervical paravertebral muscles. Cervical compression caused pain. The lumbar range of motion was decreased and painful. There was +3 tenderness to palpation of the lumbar paravertebral muscles. There was muscle spasm of the lumbar paravertebral muscles. Kemp's caused pain bilaterally. Sitting straight leg raise caused pain bilaterally. Valsalva's caused pain. The treatment plan was not reported. The rationale and Request for Authorization were not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

X-Rays Lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: The decision for x-rays of the lumbar spine is not medically necessary. The California ACOEM states lumbar x-rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least 6 weeks. However, it may be appropriate when the physician believes it would aid in patient management. Unequivocal objective findings that identify specific nerve compromise on the neurological examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurological examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminate imaging will result in false positive findings, such as disc bulges that are not the source of painful symptoms and do not warrant surgery. The injured worker did not display neurological deficits upon examination. There were no red flags on examination to warrant the need for a lumbar spine x-ray. There were no significant factors provided in the physical examination to justify x-ray of the lumbar spine. Therefore, this request is not medically necessary.

MRI Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: The decision for an MRI of the lumbar spine is not medically necessary. The ACOEM Guidelines state relying solely on imaging studies to evaluate the source of low back and related symptoms carries a significant risk of diagnostic confusion (false positive test results) because of the possibility of identifying a finding that was present before symptoms began and therefore has no temporal association with the symptoms. Techniques vary in their abilities to define abnormalities. Imaging studies should be reserved for cases in which surgery is considered or red flag diagnoses are being evaluated. Because the overall false positive rate is 30% for imaging studies in patients over 30 who do not have symptoms, the risk of diagnostic confusion is great. Magnetic resonance (MR) neurography may be useful in isolated diagnoses that do not lend themselves to back surgery, such as sciatica caused by piriformis syndrome in the hip. However, MR neurography is still new and needs to be validated by quality studies. The injured worker does not display any red flag symptoms to justify an MRI of the lumbar spine. It was not reported that the injured worker was to have surgery. The clinical information

submitted for review does not provide evidence to justify an MRI of the lumbar spine. Therefore, this request is not medically necessary.

Chiropractic Treatment: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 114.

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

Decision rationale: The decision for chiropractic treatment is not medically necessary. The California Medical Treatment Utilization Schedule states that manual therapy and manipulation is recommended for chronic pain if caused by musculoskeletal conditions. For the low back, the therapy is recommended initially in a therapeutic trial of 6 sessions and with objective functional improvement, a total of up to 18 visits over 6 to 8 weeks may be appropriate. Treatment for flare ups requires a need for re-evaluation of prior treatment success. Treatment is not recommended for the ankle and foot, carpal tunnel syndrome, the forearm, wrist, or hand, or the knee. If chiropractic treatment is going to be effective, there should be some outward sign of subjective or objective improvement within the first 6 visits. Treatment beyond 4 to 6 visits should be documented with objective improvement in function. The maximum duration is 8 weeks, and at 8 weeks, patients should be re-evaluated. Care beyond 8 weeks may be indicated for certain chronic patients in whom manipulation is helpful in improving function, decreasing pain, and improving quality of life. Medications for the injured worker were not reported. Past conservative care treatments were not reported. Therefore, this request is not medically necessary.

Diathermy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 114.

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 Pain, Diathermy

Decision rationale: The decision for diathermy is not medically necessary. The Official Disability Guidelines state that diathermy is not recommended. No proven efficacy in the treatment of acute low back symptoms. Diathermy is a type of heat treatment using either short wave or microwave energy. It has not been proven to be more effective than placebo diathermy or conventional heat therapy. The medical guidelines do not support the use of diathermy treatments. Therefore, this request is not medically necessary.

Electric Muscle Stimulation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 114.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NMES, Interferential Current Stimulation, Galvanic Stimulation, TENS, Page(s): 121, 118, 117, 1.

Decision rationale: The decision for electrical muscle stimulation is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines do not recommend neuromuscular electrical stimulation (NMES) devices as there is no evidence to support its use in chronic pain. They do not recommend interferential current stimulation (ICS) as an isolated intervention and galvanic stimulation is considered investigational for all indications. It is characterized by high voltage, pulse stimulation and is used primarily for local edema reduction through muscle pumping and polarity effect and is not recommended. The medical guidelines do recommend a 1 month trial of a TENS unit as an adjunct to a program of evidence based functional restoration for chronic neuropathic pain. Prior to the trial, there must be documentation of at least 3 months of pain and evidence that other appropriate pain modalities have been tried (including medication) and have failed. The medical guidelines do not support the use of neuromuscular electrical stimulation or interferential current stimulation. They support the use of a TENS unit as an adjunct to a program of evidence based functional restoration. The request does not indicate a TENS unit 1 month trial. Therefore, this request is not medically necessary.

Massage: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 114.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Massage Therapy Page(s): 60.

Decision rationale: The decision for massage is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines recommend massage therapy that is limited to 4 to 6 visits in most cases. Massage is beneficial in attenuating diffuse musculoskeletal symptoms, but beneficial effects were registered only during treatment. Massage is a passive intervention and treatment dependence should be avoided. This lack of long term benefits could be due to the short treatment period or treatments such as these do not address the underlying causes of pain. The injured worker's previous conservative care modalities were not reported. Also, medications for the injured worker were not reported. The clinical information submitted for review does not provide the evidence to justify a decision for massage. Therefore, this request is not medically necessary.

Ultrasound: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 114.

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, Ultrasound, Therapeutic

Decision rationale: The decision for ultrasound is not medically necessary. The Official Disability Guidelines state ultrasound, for therapeutic use, is not recommended based on the medical evidence, which shows that there is no proven efficacy in the treatment of acute low back symptoms. However, therapeutic ultrasound has few adverse effects, is not evasive, and is moderately costly, so where deep heating is desirable, providers and payors might agree in advance on a limited trial of ultrasound for the treatment of acute low back pain, but only if used as an adjunct to a program of evidence based conservative care, including exercise, but it is still not recommended by the Official Disability Guidelines. The available evidence does not support the effectiveness of ultrasound or shockwave for treating low back pain. The request submitted does not indicate which body part is to get ultrasound treatment. The medical guidelines do not support the use of ultrasound treatment. There were no other significant factors provided to justify the use outside of the current guidelines. Therefore, this request is not medically necessary.

Rib Belt: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation eMedical Article titled "Rib Fracture" (<http://emedicine.medscape.com/article/825981-treatment#showall>)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back , Lumbar Supports

Decision rationale: The decision for a rib belt is not medically necessary. The ACOEM Guidelines state that lumbar supports are not recommended for prevention. They are recommended as an option for treatment. They are recommended for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific low back pain (very low quality evidence, but may be a conservative option). The Official Disability Guidelines state that they are also for the treatment of nonspecific low back pain, compared with no lumbar support, and elastic lumbar belt may be more effective than no belt at improving pain (measured by visual analog scale) and at improving functional capacity. However, evidence is weak (very low quality evidence). The rationale to support the use and justify the use of a rib belt was not submitted. It was not reported that the injured worker had spondylolisthesis or instability. It was not reported that the injured worker was still working. It was not reported that the injured worker had a compression fracture of the superior endplate or any other type of fracture. Therefore, this request is not medically necessary.