

Case Number:	CM14-0071538		
Date Assigned:	08/08/2014	Date of Injury:	02/14/2011
Decision Date:	10/09/2014	UR Denial Date:	04/24/2014
Priority:	Standard	Application Received:	05/16/2014

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, has a subspecialty in Pain Management 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:

This is a female patient with a date of injury of February 14, 2011. A utilization review determination dated April 24, 2014 recommends non-certification of chiropractic treatments and evaluation 1 time per week for 4 weeks, physical therapy with diathermy, TENS unit, ultrasound 2 x week x 4 weeks, massage 2 x week x 4 weeks, IFC unit, tramadol 60 mg injections #2, and Naprosyn 500 mg #60. A progress note dated March 10, 2014 identifies subjective complaints of chronic low back pain secondary to small disc bulges, electromyogram (EMG) and nerve conduction velocities (NCV) of the upper extremities and lower extremities was unremarkable, she is still depressed, her wrists are currently asymptomatic, and the patient is currently working regular duty and is doing the following work activities frequent lifting of heavy objects and squatting which both aggravate her symptoms. The patient states that the prescribed medications, acupuncture, and the chiropractic treatment have been providing relief of symptoms temporarily; however she feels her condition has remained the same. The patient complains of low back pain radiating to the legs and upper back worsened by standing, sitting, and walking more than 30 minutes, lifting more than 10-pounds, pushing, pulling, bending, and stooping. The patient reports bilateral wrist pain associated with numbness, weakness, tingling sensations, and worsened symptoms by pushing, pulling, and lifting. Patient also reports bilateral foot pain is worsened by standing and walking, depression, irritability, crying spells, stress, anxiety, sexual dysfunction, sleep interruption, difficulty falling asleep, and reduced daytime alertness. Physical examination identifies tenderness the palpation over the paralumbar and gluteus muscles bilaterally, lumbosacral spasm, lumbar range of motion reveals extension of 20, flexion of 50, lateral bending of 20 with complaints of pain in all planes, and bilateral straight leg raise test is at 60 with pain in the lower extremities. Bilateral wrist examination is presently asymptomatic. Diagnoses include chronic low back pain syndrome with associated radiculitis to the lower

extremities secondary to multilevel disc bulges, history of chronic repetitive disorder of bilateral wrists/hands, carpal tunnel syndrome bilaterally, history of stress-related disorder associated with anxiety and depression, and insomnia. The treatment plan recommends Toradol 60mg for pain, vitamin B complex 1mL, Naprosyn 500mg every 12 hours for pain #60, physical therapy to the low back two times a week for four weeks consisting of diathermy, TENS, ultrasound, and massage, chiropractic treatment once a week for four weeks, the patient was advised to do strengthening exercise regimen at home, and to continue using IF-4 unit for home use for pain symptoms of the back.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic Treatment and Evaluation (once a week for four weeks): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58-60 of 127.

Decision rationale: Regarding the request for chiropractic treatments and evaluation, the Chronic Pain Medical Treatment Guidelines support the use of chiropractic care for the treatment of chronic pain caused by musculoskeletal conditions. Guidelines go on to recommend a trial of up to 6 visits over 2 weeks for the treatment of low back pain. With evidence of objective functional improvement, a total of up to 18 visits over 6 to 8 weeks may be supported. Within the documentation available for review, there is no documentation of subjective or objective functional improvement with the treatment already provided. In the absence of clarity regarding the above issues, the request is not medically necessary.

Physical Therapy (with diathermy): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines Manual therapy and manipulation.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Physical Therapy

Decision rationale: Regarding the request for physical therapy with diathermy, the Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. The Official Disability Guidelines recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, the request is for a total of 8 sessions. The current number of visits being requested

exceeds the number sessions for a trial recommended by guidelines for the patient's diagnoses. As such, the current request is not medically necessary.

Transcutaneous Electrical Nerve Stimulation (TENS) Unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-117 of 127.

Decision rationale: Regarding the request for TENS unit, the Chronic Pain Medical Treatment Guidelines state that transcutaneous electrical nerve stimulation (TENS) is 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. Guidelines recommend failure of other appropriate pain modalities including medications prior to a TENS unit trial. Prior to TENS unit purchase, one month trial 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. Within the documentation available for review, there is no indication that the patient has undergone a TENS unit trial, and no documentation of any specific objective functional deficits which a TENS unit trial would be intended to address. In the absence of clarity regarding those issues, the current request is not medically necessary.

Ultrasound (2 times per week for 4 weeks): Upheld

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

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 Chapter , Ultrasound, Therapeutic

Decision rationale: Regarding the request for ultrasound, the California MTUS does not address this issue. The Official Disability Guidelines state that it is not recommended based on the medical evidence, which shows that there is no proven efficacy in the treatment of acute low back symptoms. They go on to states that there is little evidence that active therapeutic ultrasound is more effective than placebo ultrasound for treating people with pain or a range of musculoskeletal injuries or for promoting soft tissue healing. As such, the request is not medically necessary.

Massage (2 times per week for 4 weeks): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Massage therapy Page(s): 60 of 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter, Massage Therapy

Decision rationale: Regarding the request for massage therapy, the Chronic Pain Medical Treatment Guidelines state the massage therapy is recommended as an option. They go on to state the treatment should be an adjunct to other recommended treatment (e.g. exercise), and it should be limited to 4 to 6 visits in most cases. Within the documentation available for review, the request is for a total of 8 sessions. The current number of visits being requested exceeds the maximum number of sessions recommended by guidelines for the patient's diagnoses. Finally, it is unclear exactly what objective treatment goals are hoping to be addressed with the currently requested massage therapy. As such, the requested massage therapy is not medically necessary.

Continue IF4 Unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120 of 127.

Decision rationale: Regarding the request for interferential unit, the Chronic Pain Medical Treatment Guidelines state that interferential current stimulation is not recommended as an isolated intervention. They go on to state that patient selection criteria if interferential stimulation is to be used anyways include pain is ineffectively controlled due to diminished effectiveness of medication, side effects or history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercises, or unresponsive to conservative treatment. If those criteria are met, then in one month trial may be appropriate to study the effects and benefits. With identification of objective functional improvement, additional interferential unit use may be supported. Within the documentation available for review, there is no indication that the patient has met the selection criteria for interferential stimulation (pain is ineffectively controlled due to diminished effectiveness of medication, side effects or history of substance abuse, significant pain from postoperative conditions limits the ability to perform exercises, or unresponsive to conservative treatment). Additionally, there is no documentation that the patient has undergone an interferential unit trial with objective functional improvement. In light of the above issues, the currently requested interferential unit is not medically necessary.

Tramadol (60mg, #2-injections): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 75-79 of 127.

Decision rationale: Regarding the request for tramadol injections, the Chronic Pain Medical Treatment Guidelines state that tramadol is a synthetic opiate pain medication. Due to high abuse potential, close follow-up is recommended with documentation of analgesic effect, objective functional improvement, side effects, and discussion regarding any aberrant use. Guidelines go on to recommend discontinuing opioids if there is no documentation of improved function and pain. Within the documentation available for review, there is no indication that the tramadol is improving the patient's function (in terms of specific objective functional improvement) or pain (in terms of reduced NRS, or percent reduction in pain), no documentation regarding side effects, and no discussion regarding aberrant use. In the absence of such documentation, the currently requested tramadol injections are not medically necessary.

Naprosyn (500mg, #60): Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67-72.

Decision rationale: Regarding the request for Naprosyn, the Chronic Pain Medical Treatment Guidelines state that NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Within the documentation available for review, there is no indication that Naprosyn is providing any specific analgesic benefits (in terms of percent pain reduction, or reduction in numeric rating scale), or any objective functional improvement. In the absence of such documentation, the currently requested Naprosyn is not medically necessary.