MAXIMUS Federal Services

Case Number:	CM14-0079266		
Date Assigned:	08/08/2014	Date of Injury:	02/06/2014
Decision Date:	09/22/2014	UR Denial Date:	05/08/2014
Priority:	Standard	Application Received:	05/29/2014

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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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 27-year-old female with a 2/6/14 date of injury. She injured her lower back while lifting trays and turning. On the day of injury, the patient was examined, x-rayed, and prescribed medications. The UR decision dated 5/8/14 referenced an initial comprehensive medical evaluation report dated 3/17/14, however, this report was not provided for review. According to this report, the patient had completed six sessions of physical therapy and did not significantly improve. She has also had 4 chiropractic visits. An MRI of the lumbar spine was ordered and was positive for disc herniations. Currently, the patient complained of constant, dull, achy, becoming sharp and stabbing pain with increased activities. She stated that the heels are both numb with left greater than right. Objective findings: thoracolumbar spine paravertebral spasm bilaterally, decreased sensation at the sole of the foot and anterior leg of the left lower extremity. Diagnostic impression: lumbar spine herniated nucleus pulposus with radiculopathy, secondary sleep deprivation, vomiting from medications, secondary stress and anxiety due to pain. Treatment to date: medication management, activity modification, chiropractic treatment, physical therapy. A UR decision dated 5/8/14 denied the requests for chiropractic treatment, physical therapy, X-ray of the lumbar spine, MRI of the lumbar spine, internal medicine evaluation, and home TENS unit. Regarding chiropractic treatment, the claimant had 4 prior chiropractic visits for the lumbar spine. However, there is no documented improvements as to decreased level of pain, increased range of motion, or improved functional ability with activities of daily living and work tasks. Regarding physical therapy, the patient previously completed six sessions of physical therapy and did not significantly improve. Regarding X-ray of the lumbar spine, there is no reported acute trauma or direct insult to the lumbar spine. X-rays were previously obtained and there is no indication for repeat imaging. Regarding MRI of the lumbar spine, the claimant had an MRI that was positive for disc herniations. At this time, there is no

evidence of progressive worsening of complaints or radicular symptoms to support a repeat imaging study of the lumbar spine. Regarding internal medicine evaluation, a request for pain management evaluation had been approved. The request for internal medicine evaluation is unsupported at this time. Regarding home TENS unit, there is no documentation of prior use of TENS unit in a clinical setting with evidence of objective and functional improvement noted to support home trial of TENS unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

Chiropractic treatment 2 times per week for 3 weeks for the lumbar spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 289-299,Chronic Pain Treatment Guidelines Low Back Complaints Page(s): 58. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter.

Decision rationale: California Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines state that with evidence of objective functional improvement with previous treatment and remaining functional deficits, a total of up to 18 visits is supported. In addition, elective/maintenance care is not medically necessary. The patient has completed 4 chiropractic therapy sessions. There is no documentation of objective functional gains or gains or improvement with activities of daily living from her completed sessions. In addition, there were no chiropractic treatment notes provided for review. Therefore, the request for Chiropractic treatment 2 times per week for 3 weeks for the lumbar spine was not medically necessary.

Physical therapy 2 times per week for 3 weeks for the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines General Approaches Page(s): 98-99. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Pain, Suffering, and the Restoration of Function Chapter 6, page 114 Official Disability Guidelines (ODG) Low Back Chapter.

Decision rationale: California Medical Treatment Utilization Schedule (MTUS) stresses the importance of a time-limited treatment plan with clearly defined functional goals, frequent assessment and modification of the treatment plan based upon the patient's progress in meeting those goals, and monitoring from the treating physician regarding progress and continued benefit of treatment is paramount. Physical Medicine Guidelines - Allow for fading of treatment

frequency. Official Disability Guidelines (ODG) guidelines support up to 10 physical therapy visits over 8 weeks for lumbar sprains and strains. However, the patient has completed 6 sessions of physical therapy and did not significantly improve. Guidelines do not support additional physical therapy sessions in the absence of functional improvement or pain reduction. In addition, this is a request for 6 sessions, which combined with the patient's completed 6 sessions would exceed the number of sessions supported by guidelines. Therefore, the request for Physical therapy 2 times per week for 3 weeks for the lumbar spine was not medically necessary.

X-ray for the lumbar spine: 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.

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

Decision rationale: California Medical Treatment Utilization Schedule (MTUS) states that lumbar spine 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 six weeks. The patient had an x-ray done on the date of her injury. There is no documentation of any significant changes in the patient's condition since the last x-ray to warrant repeat imaging. There is no documentation of any extenuating circumstances or red flags in the patient's condition. Therefore, the request for X-ray for the lumbar spine was not medically necessary.

MRI for the lumbar spine: 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.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304,Chronic Pain Treatment Guidelines Low Back Complaints Chapter. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter - MRI.

Decision rationale: California Medical Treatment Utilization Schedule (MTUS) supports imaging of the lumbar spine in patients with red flag diagnoses where plain film radiographs are negative; unequivocal objective findings that identify specific nerve compromise on the neurologic examination, failure to respond to treatment, and consideration for surgery. The patient had a prior Magnetic resonance imaging (MRI) of the lumbar spine that was reportedly positive for disc herniations. However, the date of this MRI is unknown. It is unclear what the patient's condition was at the time of the last report and if there has been a significant change in the patient's condition at that time. In addition, there is lack of documentation of focal neurological deficits of the lumbar spine. Therefore, the request for MRI for the lumbar spine was not medically necessary.

Internal medicine evaluation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Clinical Topics. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain ChapterAmerican College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) Chapter 6 page(s) 127, 156.

Decision rationale: California Medical Treatment Utilization Schedule (MTUS) states that consultations are recommended, and a health practitioner may refer to other specialists if a diagnosis is uncertain or extremely complex, when psychosocial factors are present or when the plan or course of care may benefit from additional expertise. The provider has not provided a rationale as to why an internal medicine evaluation is being requested. Therefore, the request for Internal medicine evaluation was not medically necessary.

Home TENS unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS units Page(s): 114-116.

Decision rationale: California Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines state that TENS units are not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option. Criteria for the use of TENS unit include Chronic intractable pain - pain of at least three months duration, evidence that other appropriate pain modalities have been tried (including medication) and failed, and a treatment plan including the specific short- and long-term goals of treatment with the TENS unit. There was no documentation in the reports reviewed addressing any failure of conservative therapy, such as medications. There was no documentation of the specific short- and long-term goals with the use of the TENS unit. Therefore, the request for Home TENS unit was not medically necessary.