MAXIMUS Federal Services

Case Number:	CM15-0003437		
Date Assigned:	02/17/2015	Date of Injury:	10/02/2010
Decision Date:	04/02/2015	UR Denial Date:	12/31/2014
Priority:	Standard	Application Received:	01/07/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
State(s) of Licensure: Hawaii, California, Iowa
Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 male patient, who sustained an industrial injury on 10/02/2010. A secondary treating office visit dated 12/08/2014 reported subjective complaint of low back pain with associated numbness and tingling to bilateral legs. The patient notices the back pain exaggerated while standing on uneven surfaces or standing upright from a sitting position. Objective findings showed diagnoses of lumbar sprain/strain; lumbar paraspinal muscle spasms/disc herniation and lumbar radiculitis, radiculopathy of lower extremities. A request was made for an epidural steroid injection under fluoroscopy to L4-5, L5-S1; a transcutaneous nerve stimulator unit, a lumbar back support and physical therapy 18 sessions. On 12/31/2014, Utilization Review, non-certified the request, noting the MTUS Epidural steroid Injections, transcutaneous nerve stimulator, along with the DG lumbar supports were cited. The injured worker submitted an application for independent medical review or services requested.

IMR ISSUES, DECISIONS AND RATIONALES

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

2nd Bi-Trans LESI @ L4-5, L5-S1 Under Fluoroscopy Guidance: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315,Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Facet joint diagnostic blocks (injections), Epidural steroid injections (ESIs), therapeuticMD Guidelines, Facet Joint Injections/Therapeutic Facet Joint Injections.

Decision rationale: ACOEM Guidelines state Invasive techniques (e.g., local injections and facet-joint injections of cortisone and Lidocaine) are of questionable merit. Although epidural steroid injections may afford short-term improvement in leg pain and sensory deficits in patients with nerve root compression due to a herniated nucleus pulposus, this treatment offers no significant long term functional benefit, nor does it reduce the need for surgery. Despite the fact that proof is still lacking, many pain physicians believe that diagnostic and/or therapeutic injections may have benefit in patients presenting in the transitional phase between acute and chronic pain. ODG and MD Guidelines agree that: One diagnostic facet joint injection may be recommended for patients with chronic low back pain that is significantly exacerbated by extension and rotation or associated with lumbar rigidity and not alleviated with other conservative treatments (e.g., NSAIDs, aerobic exercise, other exercise, manipulation) in order to determine whether specific interventions targeting the facet joint are recommended. If after the initial block/blocks are given (see Diagnostic Phase above) and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks, additional blocks may be supported. The treatment notes indicate that there was 50% improvement of symptoms after the first injection, but appears to be less than 6 weeks. The medical documents provided do not meet criteria for repeat LESI. As such, the request for 2nd Bi-Trans LESI @ L4-5, L5-S1 under Fluoroscopy Guidance is not medically necessary at this time.

TENS Unit for 3 Months: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transculaneous Electrotherapy Page(s): 114.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315,Chronic Pain Treatment Guidelines Interferential Current Stimulation, Transcutaneous electrotherapy Page(s): 54, 114-116, 118-120.

Decision rationale: ACOEM guidelines state insufficient evidence exists to determine the effectiveness of sympathetic therapy, a noninvasive treatment involving electrical stimulation, also known as interferential therapy. At-home local applications of heat or cold are as effective as those performed by therapists. MTUS further states regarding interferential units, Not recommended as an isolated intervention and details the criteria for selection: Pain is ineffectively controlled due to diminished effectiveness of medications; or Pain is ineffectively controlled with medications due to side effects; or History of substance abuse; or Significant pain from postoperative conditions limits the ability to perform exercise programs/ physical therapy treatment; or Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). If those criteria are met, then a one-month trial may be appropriate to permit the physician and physical

medicine provider to study the effects and benefits. The request for 3 months is in excess of guideline recommendations. Medical records do not detail extenuating circumstances to deviate from the guidelines at this time. As such, the request for TENS Unit for 3 Months is not medically necessary as written.

Lumbar Back Support: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) http://odg-fwc.com/odgtwc/low_back.htmACOEM Guidelines (2007 revision), pg 138-139.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back (Lumbar and Thoracic), Lumbar Support.

Decision rationale: ACOEM states, Lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. ODG states, not recommended for prevention. Recommended as an option for treatment. See below for indications. Prevention: Not recommended for prevention. There is strong and consistent evidence that lumbar supports were not effective in preventing neck and back pain. (Jellema-Cochrane, 2001) (van Poppel, 1997) (Linton, 2001) (Assendelft-Cochrane, 2004) (van Poppel, 2004) (Resnick, 2005) Lumbar supports do not prevent LBP. (Kinkade, 2007) A systematic review on preventing episodes of back problems found strong, consistent evidence that exercise interventions are effective and other interventions not effective, including stress management, shoe inserts, back supports, ergonomic/back education, and reduced lifting programs. (Bigos, 2009) This systematic review concluded that there is moderate evidence that lumbar supports are no more effective than doing nothing in preventing low-back pain. (van Duijvenbode, 2008). ODG states for use as a Treatment: Recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific LBP (very low-quality evidence, but may be a conservative option). The patient is well beyond the acute phase of treatment and the treating physician has provided no documentation of spondylolisthesis or documented instability. As such, the request for Lumbar Back Support is not medically necessary.

Physical therapy two times eight: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315,Chronic Pain Treatment Guidelines Physical Therapy, Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Physical Therapy.

Decision rationale: California MTUS guidelines refer to physical medicine guidelines for physical therapy and recommends as follows: Allow for fading of treatment frequency (from up

to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Additionally, ACOEM guidelines advise against passive modalities by a therapist unless exercises are to be carried out at home by patient. ODG quantifies its recommendations with 10 visits over 8 weeks for lumbar sprains/strains and 9 visits over 8 weeks for unspecified backache/lumbago. ODG further states that a six-visit clinical trial of physical therapy with documented objective and subjective improvements should occur initially before additional sessions are to be warranted. Medical records indicate that the patient should have graduated to home exercises at this point. The medical notes do not indicate extenuating circumstances to warrant exceeding guidelines recommendations. As such, the request for Physical therapy two times eight is not medically necessary.