

<b>Case Number:</b>	CM15-0106479		
<b>Date Assigned:</b>	06/10/2015	<b>Date of Injury:</b>	03/16/2006
<b>Decision Date:</b>	07/13/2015	<b>UR Denial Date:</b>	05/19/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/02/2015

### 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: California, Indiana, New York  
 Certification(s)/Specialty: Internal 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 59 year old male, who sustained an industrial injury on March 16, 2006. The injured worker has been treated for low back complaints. The diagnoses have included lumbar sprain/strain, lumbar paraspinal spasms, lumbar degenerative disc disease, lumbar facet arthropathy, radiofrequency ablation, Valley Fever, sacroilitis of the right sacroiliac joint and chronic pain. Treatment to date has included medications, radiological studies, physical therapy, acupuncture treatments, psychological evaluations, a transcutaneous electrical nerve stimulation unit, sacroiliac joint injections and a home exercise program. Current documentation dated April 29, 2015 notes that the injured worker reported low back pain with radiation to the bilateral lower extremities with associated numbness and tingling. The injured worker also noted progressing right buttock pain radiating to the posterior and lateral aspect of the right thigh with associated numbness and tingling. Examination revealed weakness along with numbness and tingling in the right leg. The injured worker was also noted to be suffering from severe sacroiliac joint inflammation with signs of radiculitis/radiculopathy to the posterior and lateral aspect of the thigh. Special testing was noted to be positive. The treating physician's plan of care included a request for an MRI of the lumbar spine and percutaneous neurostimulator treatments one time a week for four weeks for chronic pain.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI of the lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-5. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back section, MRI lumbar spine.

**Decision rationale:** Pursuant to the Official Disability Guidelines, MRI of the lumbar spine is not medically necessary. MRIs of the test of choice in patients with prior back surgery, but for uncomplicated low back pain, with radiculopathy, it is not recommended until after at least one month conservative therapy, sooner if severe or progressive neurologic deficit. Repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms and findings suggestive of significant pathology. Indications (enumerated in the official disability guidelines) for imaging include, but are not limited to, lumbar spine trauma, neurologic deficit; uncomplicated low back pain with red flag; uncomplicated low back pain prior lumbar surgery; etc. ACOEM states unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients not respond to treatment and who would consider surgery an option. See the ODG for details. In this case, the injured worker's working diagnoses are sacroiliitis of the right SI joint. Subjectively, according to an April 29, 2015 progress note, the injured worker complains of low back pain, decreased range of motion with tingling and numbness the bilateral lower extremities right way to the left. The pain scores 9/10. Pain radiates to the right buttock right thigh. Objectively, the treating provider discusses additional neurologic symptoms. There are no objective clinical findings and no neurologic examination in the April 29, 2015 progress note. Additionally, the injured worker had a prior magnetic resonance imaging scan of the lumbar spine. The MRI findings (according to the utilization review) correlate with the patient's subjective complaints. The documentation does not contain any red flags. There are no unequivocal objective findings that identify specific nerve compromise on the neurologic evaluation. Repeat MRI is not routinely recommended and should be reserved for a significant change in symptoms and findings suggestive of significant pathology. The documentation does not contain a significant change in symptoms and or objective findings suggestive of significant pathology. Based on the clinical information the medical record, peer-reviewed evidence-based guidelines, a prior MRI lumbar spine, and no objective clinical findings according to the April 29, 2015 progress note, MRI of the lumbar spine is not medically necessary.

**P-Stim (percutaneous neurostimulators) times four at one times a week times four week for chronic pain:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain section, Percutaneous Electrical Nerve Stimulator (PENS).

**Decision rationale:** Pursuant to the Official Disability Guidelines, percutaneous electrical nerve stimulation (PENS) times #4 at one time per week times four weeks for chronic pain is not medically necessary. PENS is not recommended as a primary treatment modality, but a trial may be considered, if used as an adjunct to a program of evidence-based functional restoration, after other nonsurgical treatments including therapeutic exercise and TENS have been tried and failed or are judged to be unsuitable or contraindicated. There is a lack of high quality evidence to prove long-term efficacy. In this case, the injured worker's working diagnoses are sacroiliitis of the right SI joint. Subjectively, according to an April 29, 2015 progress note, the injured worker complains of low back pain, decreased range of motion with tingling and numbness the bilateral lower extremities right way to the left. The pain scores 9/10. Pain radiates to the right buttock right thigh. Objectively, the treating provider discusses additional neurologic symptoms. There are no objective clinical findings and no neurologic examination in the April 29, 2015 progress note. The documentation indicates the injured worker used a TENS unit in the past that did not provide effective improvement. There is no documentation the injured worker is undergoing concurrent conservative treatment with physical therapy. There is no PENS trial documented in the medical record. Consequently, absent clinical documentation with a complete physical examination, objective neurologic evaluation and PENS trial, percutaneous electrical nerve stimulation (PENS) times #4 at one time per week times four weeks for chronic pain is not medically necessary.