

Case Number:	CM15-0016547		
Date Assigned:	02/04/2015	Date of Injury:	05/03/2007
Decision Date:	08/28/2015	UR Denial Date:	01/15/2015
Priority:	Standard	Application Received:	01/28/2015

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

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 34 year old male who reported an industrial injury on 5/3/2007. His diagnoses, and/or impressions, are noted to include: lumbar sprain/strain. No current imaging studies are noted. His treatments have included medication management; and rest from work. The progress notes of 1/7/2015 reported complaints of moderate pain, stiffness, numbness and weakness in the lumbar spine, left thigh and left knee; also complained of were sleep issues and stress. Objective findings were noted to include moderate tenderness with spasms with decreased range-of-motion and strength in the lumbar spine. The physician's requests for treatments were noted to include magnetic resonance imaging studies of the lumbar spine, an orthopedic foam mattress due to significant pain, and Norco for severe pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI L/S Upright Extension/ Flexion Views: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Special Studies and Diagnostic and Treatment Considerations.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 177, 178. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) 'Lower Back' Lumbar & Thoracic (Acute & Chronic) Chapter under MRI's, 'Lower Back' Chapter under Standing MRI's.

Decision rationale: Based on the 01/07/15 progress report provided by treating physician, the patient presents with pain to lumbar spine, left thigh and left knee. The request is for MRI L/S UPRIGHT EXTENSION/ FLEXION VIEWS. Patient's diagnosis per RFA dated 11/12/14 with associated request includes lumbar sprain/strain. Physical examination on 01/07/15 revealed tenderness to palpation to the lumbar spine, decreased strength and decreased range of motion. EMG of the lower extremities dated 07/28/12 revealed "No obvious lumbosacral radiculopathy..." Treatment to date has included electrodiagnostic studies, UDS's, medications and rest. Patient's medications include Norco, Cyclobenzaprine and Pantoprazole. The patient is permanent and stationary, per 01/07/15 report. Treatment reports were provided from 08/12/13 - 01/07/15. ACOEM Guidelines, chapter 8, page 177 and 178, state "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." ODG Guidelines, chapter Lower back 'Lumbar & Thoracic (Acute & Chronic)' and topic 'Magnetic resonance imaging (MRIs)' do not support MRIs unless there are neurologic signs/symptoms present. Repeat MRIs are indicated only if there has been progression of neurologic deficit. ODG guidelines, 'Lower Back' Chapter under 'Standing MRIs' state: "Not recommended over conventional MRIs... There is a lack of evidence in the published peer-reviewed scientific literature validating the accuracy, relevance or value of dynamic, standing or positional MRI in the diagnosis and treatment of patients with neck or back pain." Treater has not provided medical rationale for the request. Based on provided medical records, it does not appear the patient had prior MRI of the lumbar spine. In this case, the patient continues with back pain and radiating symptoms to the left leg. However, physical examination findings are unremarkable and do not corroborate evidence of radiculopathy. Furthermore, ODG guidelines do not recommend standing, Flexion/Extension MRI's over conventional MRIs due to "lack of evidence in the published peer-reviewed scientific literature validating the accuracy, relevance or value of dynamic, standing or positional MRI in the diagnosis and treatment of patients with neck or back pain." This request is not in accordance with guidelines. Therefore, the request IS NOT medically necessary.

Orthopedic Foam Mattress: 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) Low Back, Mattress Selection.

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 - Lumbar & Thoracic Chapter, under Mattress and Other Medical Treatment Guidelines Aetna guidelines, Clinical Policy Bulletin Number 0543, Hospital Beds and Accessories.

Decision rationale: Based on the 01/07/15 progress report provided by treating physician, the patient presents with pain to lumbar spine, left thigh and left knee. The request is for ORTHOPEDIC FOAM MATTRESS. Patient's diagnosis per RFA dated 11/12/14 with associated request includes lumbar sprain/strain. Physical examination on 01/07/15 revealed tenderness to palpation to the lumbar spine, decreased strength and decreased range of motion. EMG of the lower extremities dated 07/28/12 revealed "No obvious lumbosacral

radiculopathy..." Treatment to date has included electrodiagnostic studies, UDS's, medications and rest. Patient's medications include Norco, Cyclobenzaprine and Pantoprazole. The patient is permanent and stationary, per 01/07/15 report. Treatment reports were provided from 08/12/13 - 01/07/15. MTUS and ACOEM are silent on orthopedic beds. ODG-TWC, Knee & Leg Chapter, under 'Durable Medical Equipment', states that DME is defined as equipment which is primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of illness or injury. ODG-TWC, Low Back - Lumbar & Thoracic Chapter, under 'Mattress Selection' states: "There are no high quality studies to support purchase of any type of specialized mattress or bedding as a treatment for low back pain. Mattress selection is subjective and depends on personal preference and individual factors. On the other hand, pressure ulcers (e.g., from spinal cord injury) may be treated by special support surfaces (including beds, mattresses and cushions) designed to redistribute pressure. (McInnes, 2011)" Aetna guidelines, Clinical Policy Bulletin Number 0543, Hospital Beds and Accessories states: "hospital beds medically necessary" if the patient condition requires positioning of the body; e.g., to alleviate pain, promote good body alignment, prevent contractures, avoid respiratory infections, in ways not feasible in an ordinary bed; or the patient requires the head of the bed to be elevated more than 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or problems with aspiration; and the patient's condition requires special attachments (e.g., traction equipment) that cannot be fixed and used on an ordinary bed. Treater has not provided medical rationale for the request. ODG guidelines do not support "any type of specialized mattress or bedding as a treatment for low back pain." There is no mention of pressure ulcers that would warrant a special support surface. Treater has not documented that the patient presents with congestive heart failure, chronic pulmonary disease, or problems with aspiration, to meet the criteria required by AETNA guidelines, either. This request is not in accordance with guideline criteria. Therefore, the request IS NOT medically necessary.

Tens Unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of TENS Page(s): 116.

Decision rationale: Based on the 01/07/15 progress report provided by treating physician, the patient presents with pain to lumbar spine, left thigh and left knee. The request is for TENS UNIT. Patient's diagnosis per RFA dated 11/12/14 with associated request includes lumbar sprain/strain. Physical examination on 01/07/15 revealed tenderness to palpation to the lumbar spine, decreased strength and decreased range of motion. EMG of the lower extremities dated 07/28/12 revealed "No obvious lumbosacral radiculopathy..." Treatment to date has included electrodiagnostic studies, UDS's, medications and rest. Patient's medications include Norco, Cyclobenzaprine and Pantoprazole. The patient is permanent and stationary, per 01/07/15 report. Treatment reports were provided from 08/12/13 - 01/07/15. According to MTUS Chronic Pain Management Guidelines the criteria for use of TENS in chronic intractable pain (p116) "a one month trial period of the TENS unit should be documented (as an adjunct to other 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 during this trial." Treater has not provided medical rationale for the request, nor indicated whether this is a rental or for home use. MTUS requires documentation of how often the unit was used, pain relief and goals during a one month trial, prior to dispensing home TENS units. Furthermore, treater has not indicated what body part would be treated. This patient does not

present with a diagnosis indicated for the use of TENS. MTUS recommends TENS for neuropathic pain, CRPS, Multiple Sclerosis, Phantom pain, and spasticity pain. The patient presents with back musculoskeletal pain. This request is not in accordance with guidelines. Therefore, the request IS NOT medically necessary.

Norco 10mg/325 P.O Q.H.S: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medications for chronic pain CRITERIA FOR USE OF OPIOIDS Page(s): 60,61, 76-78, 88,89, 80,81.

Decision rationale: Based on the 01/07/15 progress report provided by treating physician, the patient presents with pain to lumbar spine, left thigh and left knee. The request is for NORCO 10MG/325 P.O Q.H.S. Patient's diagnosis per RFA dated 11/12/14 includes lumbar sprain/strain. Physical examination on 01/07/15 revealed tenderness to palpation to the lumbar spine, decreased strength and decreased range of motion. EMG of the lower extremities dated 07/28/12 revealed "No obvious lumbosacral radiculopathy..." Treatment to date has included electrodiagnostic studies, UDS's, medications and rest. Patient's medications include Norco, Cyclobenzaprine and Pantoprazole. The patient is permanent and stationary, per 01/07/15 report. Treatment reports were provided from 08/12/13 - 01/07/15. MTUS Guidelines pages 88 and 89 states, "Pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 also requires documentation of the 4As (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work and duration of pain relief. MTUS p77 states, "function should include social, physical, psychological, daily and work activities, and should be performed using a validated instrument or numerical rating scale." MTUS p90 states, "Hydrocodone has a recommended maximum dose of 60mg/24 hrs." Norco has been included in patient's medications, per progress reports dated 11/12/15, 12/12/14, and 01/07/15. Treater has not indicated quantity in the request. RFA dated 11/12/14 states "Norco 10/325 #60 x 5 Refills." MTUS p80, 81 states regarding chronic low back pain: "Appears to be efficacious but limited for short-term pain relief, and long-term efficacy is unclear (>16 weeks), but also appears limited." Long-term use of opiates may be indicated for nociceptive pain as it is "Recommended as the standard of care for treatment of moderate or severe nociceptive pain (defined as pain that is presumed to be maintained by continual injury with the most common example being pain secondary to cancer)." However, this patient does not present with pain that is "presumed to be maintained by continual injury." Furthermore, treater has not stated how Norco reduces pain and significantly improves patient's activities of daily living. There are no pain scales or validated instruments addressing analgesia. MTUS states that "function should include social, physical, psychological, daily and work activities." UDS's dated 12/02/13 and 08/12/13 revealed inconsistent results. In addition, there are no specific discussions regarding aberrant behavior, adverse reactions, ADLs, etc. No opioid pain agreement or CURES reports. MTUS requires appropriate discussion of the 4As. Given the lack of documentation as required by guidelines and inconsistent UDS's, the request IS NOT medically necessary.