

Case Number:	CM15-0196209		
Date Assigned:	10/09/2015	Date of Injury:	05/20/2014
Decision Date:	12/18/2015	UR Denial Date:	09/14/2015
Priority:	Standard	Application Received:	10/06/2015

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, Pain Management

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 29 year old female who sustained an industrial injury on May 20, 2014. A recent primary treating office visit dated September 09, 2015 reported subjective complaint of "continues to experience progressive low back pain and limited range of motion of lumbar spine associated with muscle spasms." The plan of care is with recommendation for: right sacroiliac joint injection; MRI of lumbar spine and right wrist; lumbar support and TENS unit. A secondary treating office visit dated June 24, 2015 reported subjective complaint of "low back pain, limited range of motion of lumbar spine and associated numbness and tingling." There is also "pain in the right wrist with limited range of motion of the upper extremity." There is also "limited cervical range of motion with frequent headaches and blurry vision." She complains of "constant, sharp, throbbing pain on the right side of arm." She also states "no able to sleep for long periods without the help of pain medications or sleep aide." The following diagnoses were applied to this visit: limited range of motion of the right wrist; lumbar sprain and strain; lumbar paraspinal muscle spasms, disc herniation; lumbar radiculitis, radiculopathy of lower extremities, and chronic pain. The plan of care is with requesting recommendation for: MRI of lumbar spine; consideration for MRI of right wrist ruling out tear; and reconsideration for orthopedic evaluation of right wrist. There is further recommendation for a percutaneous neurostimulator unit ASAP which was noted with previous denial. There is also recommendation for lumbar back support and random urine toxicology. At secondary treating in July 29, 2015 the plan of care is noted with requesting recommendation for: MRI of lumbar spine and right wrist; right sacroiliac joint injection, course of physical therapy; prescribed Norco and Gabapentin; lumbar support and prescribed topical compound creams. On

September 04, 2015 a request was made for MRI of lumbar spine; right sacroiliac joint injection under fluoroscopy guidance; physical therapy 12 sessions treating lumbar spine and bilateral sacroiliac joints and DME lumbar support brace that were noncertified by Utilization Review on September 14, 2015.

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: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, MRI Topic.

Decision rationale: Regarding the request for lumbar MRI, ACOEM Practice Guidelines state that unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. ODG states that MRIs are recommended for uncomplicated low back pain with radiculopathy after at least one month of conservative therapy. They are the test of choice for patients with previous back surgery. Typically, the indications for MRI require that x-rays of the lumbar spine be performed first and are non-diagnostic. Within the documentation available for review, there is identification of any objective findings that suggest nerve compromise. A progress note from 6/24/15 indicates that the patient has weakness and tingling. On exam, there is documentation of pain around L4 and reproduction of L4 dermatomal pain with palpation. Then in a follow-up note from July 2015, the provider documents L3, L4, L5 radiculopathy under the objective findings section. However, the records do not discuss prior imaging or prior conservative treatment to date. Given this, the currently requested lumbar MRI is not medically necessary. However, as soon as this information is supplied, and if there has been a progressive deterioration in the patient's status, then MRI may be appropriate in this case.

Right SI joint injection under fluoroscopy guidance: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Hip and Pelvis Chapter, Sacroiliac Blocks.

Decision rationale: Regarding the request for sacroiliac joint injections, guidelines recommend sacroiliac blocks as an option if the patient has failed at least 4 to 6 weeks of aggressive conservative therapy. The criteria include: history and physical examination should suggest a

diagnosis with at least three positive exam findings and diagnostic evaluation must first address any other possible pain generators. Within the documentation available for review, there is indication of at least three positive examination findings suggesting a diagnosis of sacroiliac joint dysfunction. This is noted in a progress note dated 7/29/15 and the patient has positive Faber's, Gaenslen's, and thrust testing. However, it is unclear whether conservative therapy of 4-6 weeks has taken place. Additionally, it appears there is a concomitant request for PT at this time. Given this, the currently requested sacroiliac joint injections are not medically necessary.

Physical therapy 2x6 for lumbar spine and bilateral sacroiliac joints: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Physical Therapy.

Decision rationale: Regarding the request for physical therapy, 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 especially in sacroiliac joint dysfunction. ODG 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. The ODG states the following: "Sprains and strains of sacroiliac region (ICD9 846): Medical treatment: 10 visits over 8 weeks." Within the documentation available for review, this request has been made for 12 visits. Unfortunately, the IMR process cannot modify requests and the present request exceeds guideline recommendations. Given this, the current request for physical therapy is not medically necessary.

Lumbar support size medium: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Lumbar Supports.

Decision rationale: Regarding the request for lumbar support/brace, ACOEM guidelines state that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. ODG states that lumbar supports are not recommended for prevention. They go on to state the lumbar support are recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific low back pain. ODG goes on to state that for nonspecific low back pain, compared to no lumbar support, elastic lumbar belt maybe more effective than no belt at improving pain at 30 and 90 days in people with subacute low back pain lasting 1 to 3 months. However,

the evidence was very weak. Within the documentation available for review, it does not appear that this patient is in the acute or subacute phase of his treatment as this has been ongoing x1 year. Additionally, there is no documentation indicating that the patient has a diagnosis of compression fracture, spondylolisthesis, or instability. As such, the currently requested lumbar brace is not medically necessary.

P-Stim times 4: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation United Health Care, Coverage Summary for Complementary and Alternative Medicine (last reviewed 7/21/2015) Medicare, National Coverage Determination Biegler, Manufacturer of P Stim <http://www.biegler.com/pstim.en.html>.

Decision rationale: With regard to the request for P Stim, the CA MTUS, ACOEM, and ODG do not address this modalities. This is a type of peripheral stimulator which targets auricular acupuncture points to decrease chronic pain. Per the manufacturer's website, the "P-STIM is a miniaturized device designed to administer auriculo point stimulation treatment over several days." Therefore, additional references in the form of Medicare and UHC Policy Guidelines are cited. The UHC Coverage Summary on Complementary and Alternative Medicine states that "Electrical Stimulation of Auricular Acupuncture Points (also known as Electro-acupuncture stimulation) using P-Stim" (HCPCS code S8930, CPT code 64553 and HCPCS L8680) are not covered." Based upon a lack of quality peer reviewed literature to support its use, and guideline recommendations from national insurance carrier against its use, the requested P Stim is not medically necessary.