

<b>Case Number:</b>	CM15-0201949		
<b>Date Assigned:</b>	10/19/2015	<b>Date of Injury:</b>	12/30/2014
<b>Decision Date:</b>	12/23/2015	<b>UR Denial Date:</b>	09/22/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/14/2015

### 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: Emergency 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 41 year old male who sustained an industrial injury 12-30-14. A review of the medical records reveals the injured worker is undergoing treatment for anxiety, cervicobrachial syndrome, thoracalgia, lumbar facet syndrome, sacroiliac inflammation, bilateral knee tenosynovitis, probable post-traumatic headaches and anxiety, posttraumatic anxiety and depression. Medical records (02-12-15) reveal the injured worker complains of posterior neck and upper back pain rated at 6/10, mid back pain rated at 7/10, rig knee pain rated at 5/10, and left knee pin rated at 8/10, as well as anxiety, insomnia, and headaches. He also complained of lower back pain rated at 0/10. The physical exam (02-12-15) reveals diminished and painful range of motion of the cervical and lumbar spines and bilateral knees. Prior treatment includes medications including ibuprofen, trazadone, Amitriptyline, Methocarbamol, tramadol, and Prilosec, as well as a knee brace and a psychiatric evaluation. The original utilization review (09-22-15) non certified the request for 6 chiropractic sessions and MRIs of the lumbar and cervical spines. There is no documentation of any previous radiological studies or chiropractic treatment.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**6 sessions of chiropractic consisting of manipulation of 3-4 areas, therapeutic exercise, electrical stimulation and myofascial release 2x week for 5 weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation, Exercise, Massage therapy. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back (Acute and Chronic): Electrical muscle stimulation.

**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 (Acute & Chronic)/Manipulation, Lumbar the thoracic/TENS (transcutaneous electrical nerve stimulation).

**Decision rationale:** The request is for multiple treatments including chiropractic therapy, therapeutic exercise, and TENS. The guidelines support the use of manipulation with an initial trial of 6 visits over 2 week and with evidence of objective functional improvement additional therapy. With regards to electrical stimulation, the guidelines state the following: The request is for the use of TENS unit therapy to aid in low back pain. The ODG state the following regarding this topic: Not recommended as an isolated intervention, but a one-month home-based TENS trial may be considered as a noninvasive conservative option for chronic back pain, if used as an adjunct to a program of evidence-based conservative care to achieve functional restoration, including reductions in medication use. Acute: Not recommended based on published literature and a consensus of current guidelines. No proven efficacy has been shown for the treatment of acute low back symptoms. (Herman, 1994) (Bigos, 1999) (van Tulder, 2006) Chronic: Not generally recommended, as there is strong evidence that TENS is not more effective than placebo or sham. (Airaksinen, 2006) There is minimal data on how efficacy is affected by type of application, site of application, treatment duration, and optimal frequency/intensity. (Brousseau, 2002) There are sparse randomized controlled trials that have investigated TENS for low back pain. One study of 30 subjects showed a significant decrease in pain intensity over a 60-minute treatment period and for 60 minutes after. (Cheing, 1999) A larger trial of 145 subjects showed no difference between placebo and TENS treatment. (Deyo, 1990) Single-dose studies may not be effective for evaluating long-term outcomes, or the standard type of use of this modality in a clinical setting. (Milne-Cochrane, 2001) (Sherry, 2001) (Philadelphia Panel, 2001) (Glaser, 2001) (Maher, 2004) (Brousseau, 2002) (Khadikar, 2005) (Khadikar2, 2005) Although electrotherapeutic modalities are frequently used in the management of CLBP, few studies were found to support their use. Most studies on TENS can be considered of relatively poor methodological quality. TENS does not appear to have an impact on perceived disability or long-term pain. High frequency TENS appears to be more effective on pain intensity when compared with low frequency, but this has to be confirmed in future comparative trials. It is also not known if adding TENS to an evidence-based intervention, such as exercise, improves even more outcomes, but studies assessing the interactions between exercise and TENS found no cumulative impact. (Poitras, 2008) For more information, see the Pain Chapter. Recent research: A recent meta-analysis concluded that the evidence from the small number of placebo-controlled trials does not support the use of TENS in the routine management of chronic LBP. There was conflicting evidence about whether TENS was beneficial in reducing back pain intensity and consistent evidence that it did not improve back-specific functional status. There was moderate

evidence that work status and the use of medical services did not change with treatment. Patients treated with acupuncture-like TENS responded similarly to those treated with conventional TENS. (Khadilkar-Cochrane, 2008) On June 8, 2012, the Centers for Medicare & Medicaid Services (CMS) issued an updated decision memo concluding that TENS is not reasonable and necessary for the treatment of chronic low back pain based on a lack of quality evidence for its effectiveness. Coverage is available only if the beneficiary is enrolled in an approved clinical study. (Jacques, 2012) As stated above the use of TENS therapy in acute low back pain is not indicated. There is also poor evidence of utility in chronic low back pain as well, with the Centers of Medicare & Medicaid Services stating, "TENS is not reasonable and necessary for the treatment of chronic low back pain based on a lack of quality evidence for its effectiveness." As such, the request is not medically necessary.

### **1 orthopedic consult:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Surgical Considerations. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back- Lumbar & Thoracic (Acute and Chronic): Office visits.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (chronic)/Office visits.

**Decision rationale:** The request is for an orthopedic surgery consultation. The MTUS guidelines are silent regarding this issue. The ODG state the following: Recommended as determined to be medically necessary. Evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The determination is also based on what medications the patient is taking, since some medicines such as opiates, or medicines such as certain antibiotics, require close monitoring. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment, being ever mindful that the best patient outcomes are achieved with eventual patient independence from the health care system through self care as soon as clinically feasible. The ODG Codes for Automated Approval (CAA), designed to automate claims management decision-making, indicates the number of E&M office visits (codes 99201-99285) reflecting the typical number of E&M encounters for a diagnosis, but this is not intended to limit or cap the number of E&M encounters that are medically necessary for a particular patient. Office visits that exceed the number of office visits listed in the CAA may serve as a "flag" to payors for possible evaluation, however, payors should not automatically deny payment for these if preauthorization has not been obtained. Note: The high quality medical studies required for treatment guidelines such as ODG provides guidance about specific treatments and diagnostic procedures, but not about the recommended number of E&M office visits. Studies have and are being conducted as to the value of "virtual visits" compared with inpatient visits; however, the value of patient/doctor interventions has not been questioned. (Dixon, 2008) (Wallace, 2004) Further, ODG does provide guidance for therapeutic office visits not included among the

E&M codes, for example Chiropractic manipulation and Physical/Occupational therapy. See also Telehealth. In this case, the request is not medically necessary. This is secondary to current therapy being undertaken which is still incomplete. There is also no discussion of surgical measures thought to be needed or "red flags" seen on exam.

**MRI of the cervical spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Neck and Upper Back Complaints 2004, Section(s): Diagnostic Criteria, Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back: Magnetic resonance imaging (MRI).

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Neck and upper back complaints/MRI.

**Decision rationale:** The request is for an MRI. The ACOEM guidelines state that when there is physiological evidence of tissue insult or neurological deficits, consider a discussion with a consultant regarding the next steps including MRI imaging. An imaging study may be appropriate in patients where symptoms have lasted greater than 4-6 weeks and surgery is being considered for a specific anatomic defect or to further evaluate the possibility of serious pathology, such as a tumor. Reliance on imaging studies alone to evaluate the source of neck or upper back symptoms carries a significant risk of diagnostic confusion (false-positive test results) because it is possible to identify a finding that was present before symptoms began and, therefore, has no temporal association with the symptoms. The ODG guidelines regarding qualifying factors for an MRI of the neck or upper back are as follows: Indications for imaging - MRI (magnetic resonance imaging): Chronic neck pain (after 3 months conservative treatment), radiographs normal, neurologic signs or symptoms present; Neck pain with radiculopathy if severe or progressive neurologic deficit; Chronic neck pain, radiographs show spondylosis, neurologic signs or symptoms present; Chronic neck pain, radiographs show old trauma, neurologic signs or symptoms present; Chronic neck pain, radiographs show bone or disc margin destruction- Suspected cervical spine trauma, neck pain, clinical findings suggest ligamentous injury (sprain), radiographs and/or CT "normal;" Known cervical spine trauma: equivocal or positive plain films with neurological deficit; Upper back/thoracic spine trauma with neurological deficit. In this case, there is inadequate documentation in a change in neurologic status seen on exam. The records do not indicate new "red flags" which would warrant further imaging evaluation. Pending further information regarding new neurologic deficits, the request is not medically necessary.

**MRI of the lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Diagnostic Criteria, Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back- Lumbar and Thoracic: MRIs.

**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 (Acute & Chronic)/ MRIs (magnetic resonance imaging).

**Decision rationale:** The request is for an MRI of the lumbar spine. The ODG guidelines state the following regarding qualifying criteria: Indications for imaging - Magnetic resonance imaging: Thoracic spine trauma: with neurological deficit; Lumbar spine trauma: trauma, neurological deficit; Lumbar spine trauma: seat belt (chance) fracture (If focal, radicular findings or other neurologic deficit); Uncomplicated low back pain, suspicion of cancer, infection, other "red flags;" Uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit; Uncomplicated low back pain, prior lumbar surgery; Uncomplicated low back pain, cauda equina syndrome; Myelopathy (neurological deficit related to the spinal cord), traumatic; Myelopathy, painful; Myelopathy, sudden onset; Myelopathy, stepwise progressive; Myelopathy, slowly progressive; Myelopathy, infectious disease patient; Myelopathy, oncology patient; Repeat MRI: When there is significant change in symptoms and/or findings suggestive of significant pathology (e.g., tumor, infection, fracture, neurocompression, recurrent disc herniation). In this case, the patient would not qualify for an MRI based on the above set standards. This is secondary to a lack of a change in clinical status or described "red flags". There is a lack of documentation of progressive neurologic deficit. Pending further information revealing qualifying indications as listed above, the request is not medically necessary.