

<b>Case Number:</b>	CM15-0046182		
<b>Date Assigned:</b>	03/18/2015	<b>Date of Injury:</b>	01/31/2011
<b>Decision Date:</b>	05/08/2015	<b>UR Denial Date:</b>	02/10/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/11/2015

### 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: Preventive Medicine, Occupational Medicine, Public Health & General Preventive 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 66-year-old male who reported injury on 01/31/2011. The mechanism of injury was cumulative trauma. The documentation of 06/15/2011 revealed the injured worker had complaints of low back pain, right knee pain, and had locking and giving way of the right knee with walking and standing greater than 10 minutes. The injured worker had complaints of stress, anxiety, depression, and sleeping difficulty. The objective findings revealed physical therapy 2 times a week provided partial relief. The injured worker had a positive straight leg raise into both calf muscles and had spasms and a positive McMurray's with decreased range of motion and guarding. The diagnoses included bilateral lower extremity radiculopathy. The treatment plan included a continuation of physical therapy. The documentation of 08/03/2011 revealed the injured worker had pain in the low back with ongoing stress, anxiety, and depression and the injured worker had a positive straight leg raise into both calf muscles. The injured worker had spasms and tenderness at the SST, SA, and AC joint. The right knee examination revealed a positive McMurray's and decreased range of motion. The diagnoses remained the same. The treatment plan included continued physical therapy 1 x4 and spinal decompression for 12 sessions for treatment of discopathy and pain. The documentation of 09/14/2011 revealed pain in the low back and right knee that was increasing with bending, lifting, standing, and walking. The objective findings included spinal decompression 2 times a week provided partial relief. The injured worker's physical examination remained the same. The treatment plan included a sleep study due to sleep difficulties. Additionally, there was a request

for continuation of lumbar spine decompression therapy. The medications and surgical history were not provided.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **5 visits of spinal decompression therapy between 8/3/11 and 9/30/11: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300.

**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 Chapter, IDD therapy (intervertebral disc decompression).

**Decision rationale:** The Official Disability Guidelines indicate that intervertebral disc decompression is not recommended as it has not been shown to be effective. There was a lack of documentation of objective findings upon examination to support the necessity for spinal decompression therapy. There was a lack of documentation of exceptional factors to warrant nonadherence to guideline recommendations. Given the above, the request for 5 visits of spinal decompression therapy between 8/3/11 and 9/30/11 is not medically necessary.

#### **1 sleep study between 9/14/11 and 10/28/11: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation California Official Medical Fee Schedule, 1999, page 460.

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

**Decision rationale:** The Official Disability Guidelines indicate that polysomnography is recommended for injured workers who have insomnia complaints for at least 6 months, which are at least 4 nights a week that are unresponsive to behavioral interventions and sedatives/sleep promoting medications, and when psychiatric etiology has been excluded. Additionally, it is recommended for injured workers who have a combination of excessive daytime somnolence, cataplexy, morning headaches, intellectual deterioration, personality changes, or sleep related breathing disorder or periodic limb movement disorder is suspected. The clinical documentation submitted for review failed to provide documentation that the injured worker had at least 6 months of insomnia complaints that were unresponsive to behavioral interventions and sedatives/sleep promoting medications and that psychiatric etiology had been ruled out. There was a lack of documentation indicating the injured worker had excessive daytime somnolence, cataplexy, morning headache, intellectual deterioration, personality change, sleep related breathing disorder, or that there was a suspicion of periodic limb movement disorder. Given the above, the request for 1 sleep study between 9/14/11 and 10/28/11 is not medically necessary.

**1 TENS unit with moist heating pad: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298, Chronic Pain Treatment Guidelines TENS unit Page(s): s 114-116.

**Decision rationale:** The California MTUS recommends a 1 month trial of a TENS unit as an adjunct to a program of evidence based, ongoing treatment modalities within a functional restoration approach for chronic neuropathic pain. Prior to the trial there must be documentation of at least 3 months of pain and evidence that other appropriate pain modalities have been tried (including medication) and have failed. The American College of Occupational and Environmental Medicine Guidelines indicate that at home local applications of cold in first few days of acute complaint are appropriate and thereafter, applications of heat or cold are appropriate. The clinical documentation submitted for review failed to provide documentation that other appropriate pain modalities have been tried and failed. There was a lack of documentation of exceptional factors. Additionally, there was a lack of documentation indicating a necessity for a moist heating pad. The request as submitted failed to indicate whether the request was for rental or purchase of a TENS unit and a moist heating pad. Given the above, the request for 1 TENS unit with moist heating pad is not medically necessary.

**10 physical therapy visits between 6/15/11 and 7/21/11: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): s 98 and 99.

**Decision rationale:** The California Medical Treatment Utilization Schedule Guidelines recommend physical medicine for myalgia and myositis for up to 10 visits. The prior therapies were not provided. However, the date of injury was 01/31/2011, and as prior therapies were not provided, there could be no determination as to whether physical therapy would be appropriate at this juncture. The request as submitted failed to indicate the body part to be treated with therapy. Given the above, the request for 10 physical therapy visits between 6/15/11 and 7/21/11 is not medically necessary.

**1 videofluoroscopic evaluation between 4/19/11 and 4/26/11: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Lumbar & Thoracic (Acute & chronic).

**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 Chapter, Fluoroscopy (for ESI's).

**Decision rationale:** The Official Disability Guidelines indicate that fluoroscopy is appropriate for epidural steroid injections. There was a lack of documented rationale for the use of video fluoroscopy. There was no physician documentation requesting a video fluoroscopy examination submitted for review. The request as submitted failed to indicate the body part to be evaluated. Given the above and the lack of documentation, the request for 1 videofluoroscopic evaluation between 4/19/11 and 4/26/11 is not medically necessary.