

Case Number:	CM15-0051299		
Date Assigned:	04/17/2015	Date of Injury:	10/31/1996
Decision Date:	05/18/2015	UR Denial Date:	03/17/2015
Priority:	Standard	Application Received:	03/18/2015

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 65 year old female, who sustained an industrial injury on 10/31/1996. The current diagnoses are chronic pain syndrome, lumbago, myalgia and myositis, thoracic or lumbosacral neuritis or radiculitis, and post laminectomy syndrome of the lumbar region. According to the progress report dated 3/3/2015, the injured worker complains of back and bilateral lower extremity pain associated with numbness and weakness. The pain is described as constant, intermittent, sharp, dull, aching, burning, cramping, radiating, stabbing, grinding, and pins and needles. The pain is rated 8/10 on a subjective pain scale. The current medications are Neurontin, Xanax, Lexapro, Duragesic patch, Lidoderm, and Cyclobenzaprine. Treatment to date has included medication management, heat, ice, physical therapy, stretching, acupuncture, and surgical intervention. The plan of care includes pulse stimulation treatment, continue passive airway pressure machine, and trigger point injections.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pulse Stimulation Treatment (PSTIM): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Percutaneous electrical nerve stimulation (PENS) Page(s): 97.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines, Pain chapter, Auricular electro-acupuncture.

Decision rationale: The patient was injured on 10/31/96 and presents with mid back pain, low back pain, leg/foot pain, leg/foot numbness, leg weakness, headaches, neck pain, arm/hand pain, arm/hand numbness, arm/hand weakness, and hip pain. The request is for PULSE STIMULATION TREATMENT (PSTIM) for the lumbar spine. The RFA is dated 03/03/15 and the patient's work status is not provided. P-Stim is a proprietary auricular acupuncture device. ODG Pain chapter, under Auricular electro-acupuncture has the following: "Not recommended. The evidence is insufficient to evaluate the effect of auricular electro-acupuncture on acute and chronic pain. In the only published RCT, use of the P-Stim device was not associated with improved pain management. Auricular electro-stimulation or ear-acupuncture is a type of ambulatory electrical stimulation of acupuncture points on the ear. Devices, including the P-Stim" and E-pulse, have been developed to provide continuous or intermittent stimulation over a period of several days. This type of electro-stimulation is being evaluated for a variety of conditions, including pain, depression, and anxiety. Both the P-Stim () and the E-pulse () devices have received marketing clearance through the FDA abbreviated 510(k) process for use in treating acute or chronic pain by a qualified practitioner of acupuncture." There is tenderness to palpation along the upper and mid lumbar paraspinals, an abnormal lumbar spine range of motion, and decreased sensation to light touch at left L5. The patient is diagnosed with chronic pain syndrome, lumbago, myalgia and myositis, thoracic or lumbosacral neuritis or radiculitis, and post laminectomy syndrome of the lumbar region. In regard to the purchase of a home-use P-Stim unit for this patient's continuing lumbar spine pain, the requested device is not supported by guidelines. While this patient presents with significant pain in the lower back and has an extensive treatment history directed at these complaints, ODG does not support the use of Auricular electro-acupuncture for chronic pain unless it is being used by a "qualified practitioner of acupuncture." In this case, there is no indication if this machine will be used at-home or by the qualified practitioner. P-Stim devices are FDA approved only for use by qualified acupuncture practitioners, not for personal in-home use. Therefore, the requested pulse stimulation treatment IS NOT medically necessary.

CPAP (Continuous positive airway pressure) machine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation AIM Specialty Health 2014 May, page 6.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Pulmonary (Acute & Chronic) chapter, Noninvasive positive pressure ventilation (NPPV).

Decision rationale: The patient was injured on 10/31/96 and presents with mid back pain, low back pain, leg/foot pain, leg/foot numbness, leg weakness, headaches, neck pain, arm/hand pain, arm/hand numbness, arm/hand weakness, and hip pain. The request is for CPAP (CONTINUOUS POSITIVE AIRWAY PRESSURE) MACHINE for diagnosis of obstructive

sleep apnea. The RFA is dated 03/03/15 and the patient's work status is not provided. Regarding Noninvasive positive pressure ventilation (NPPV), ODG guidelines recommends "in patients with COPD and ventilatory failure and may be useful as an adjunct in patients with severe COPD as part of a pulmonary rehabilitation program. (Ries, 2007) Of value in acute exacerbations of COPD but not recommended in the stable patient, with or without CO2 retention. In these patients, there is no effect on dyspnea, exercise tolerance, arterial blood gases, respiratory muscle strength, or quality of life." In this case, there is no documentation of any sleep issues such as obstructive sleep apnea the patient may be having. There is no sleep studies recommending a CPAP. Furthermore, the treating physician does not document that the patient had "COPD and ventilatory failure." The requested CPAP machine IS NOT medically necessary.

Trigger Point Injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger point injections Page(s): 122.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger point injections Page(s): 122. Decision based on Non-MTUS Citation Official disability guidelines neck chapter, trigger points injection.

Decision rationale: The patient was injured on 10/31/96 and presents with mid back pain, low back pain, leg/foot pain, leg/foot numbness, leg weakness, headaches, neck pain, arm/hand pain, arm/hand numbness, arm/hand weakness, and hip pain. The request is for a TRIGGER POINT INJECTION for bilateral lumbar and thoracic paraspinal muscles. The RFA is dated 03/03/15 and the patient's work status is not provided. Review of the reports provided does not indicate if the patient had any prior trigger point injections. ODG guidelines, neck chapter, trigger points injection section, states the following: "Not recommended in the absence of myofascial pain syndrome. See the pain chapter for criteria for the use of trigger point injections. The effectiveness of trigger point injection is uncertain, in part due to the difficulty of demonstrating advantages of active medication over injection of saline. Needling alone may be responsible for some of the therapeutic response. The only indication with some positive data is myofascial pain; maybe appropriate when myofascial trigger points are present on examination. Trigger point injections are not recommended when there are radicular signs, but they may be used for cervicgia." MTUS guidelines, page 122, state that "Trigger point injections with a local anesthetic may be recommended for the treatment of chronic low back or neck pain with myofascial pain syndrome when all of the following criteria are met: 1. documentation of circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain; 2. symptoms have persisted for more than three months; 3. medical management therapy such as ongoing stretching exercises, physical therapy, NSAIDs and muscle relaxants have failed to control pain; 4. radiculopathy is not present (by exam, imaging, or neuro testing); 5. not more than three to four injections per session; 6. no repeat injections unless a greater than 50% pain relief is obtained for six weeks after an injection and there is documented evidence of the functional improvement; 7. frequency should not be at an interval less than two months; 8. trigger point injections with any substance (saline or glucose) other than local anesthetic. There is tenderness to palpation along the upper and mid lumbar paraspinals, an abnormal lumbar spine range of motion, and decreased sensation to light touch at left L5. The patient is diagnosed with

chronic pain syndrome, lumbago, myalgia and myositis, thoracic or lumbosacral neuritis or radiculitis, and post laminectomy syndrome of the lumbar region. There are no documented circumscribed trigger points with evidence upon palpation of a twitch response, as required by MTUS guidelines. Furthermore, the patient presents with radiculopathy which is not indicated by MTUS guidelines. The request does not meet guideline criteria. The requested trigger point injection IS NOT medically necessary.