

Case Number:	CM15-0053245		
Date Assigned:	03/26/2015	Date of Injury:	10/08/2002
Decision Date:	05/14/2015	UR Denial Date:	03/06/2015
Priority:	Standard	Application Received:	03/20/2015

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 male who sustained an industrial injury on 10/8/02 when he fell resulting in injury to his low back and bilateral knees. Two years later he was found to have coccidiomycosis invading his lungs followed by meningeal infection. His back pain worsened and was found to have a spinal abscess. With the draining of the abscess he had anterior and posterior instrumentation and woke up paraplegic. He uses a wheelchair for mobility. He currently complains of low to mid back pain. No medications were identified. Diagnoses include right knee arthroscopy with lateral meniscectomy and major synovectomy (5/03); bilateral open reduction internal fixation for bilateral femur fracture (2012); bilateral knee chondromalacia; lumbar spine sprain/ strain with disc protrusion, L5-S1; paraplegia following spinal surgery (9/13/07). Treatments to date include medications, back brace. Diagnostics include MRI bilateral knees (2/03) showing right knee meniscus tear; MRI lumbar spine (9/18/03, 6/27/04, 6/6/07); MRI left knee (8/27/04); MRI thoracic spine (7/2/07); x-ray bilateral knees. In the progress note dated 2/12/15 the treating provider's plan of care includes requesting lumbar brace, chiropractic therapy to decrease back pain and spasm and ART-meds 4 unit for pain to prevent further atrophy.

IMR ISSUES, DECISIONS AND RATIONALES

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

One lumbar brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298, 301.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official disability guidelines Low Back Lumbar & Thoracic Chapter, lumbar supports.

Decision rationale: The patient presents with low to mid back pain. The request is for One Lumbar Brace. There is no RFA provided and the date of injury is 10/08/02. The diagnoses include right knee arthroscopy with lateral meniscectomy and major synovectomy (5/03); bilateral open reduction internal fixation for bilateral femur fracture (2012); bilateral knee chondromalacia; lumbar spine sprain/ strain with disc protrusion, L5-S1; paraplegia following spinal surgery (9/13/07). Per 02/12/15, physical examination revealed no active motion of the lower extremities. There is severe atrophy of the bilateral low extremities with right greater than left. The patient is permanent and stationary. ACOEM Guidelines page 301 on lumbar bracing states, "lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief". ACOEM guidelines further state that they are not recommended for treatment, but possibly used for prevention if the patient is working. ODG Low Back Lumbar & Thoracic Chapter, lumbar supports topic, states, "Recommended as an option for compression fractures and specific treatment of spondylolisthesis, documented instability, and for treatment of nonspecific LBP (very low-quality evidence, but may be a conservative option)". For post-operative bracing, ODG states, "Under study, but given the lack of evidence supporting the use of these devices, a standard brace would be preferred over a custom post-op brace, if any, depending on the experience and expertise of the treating physician." Per 02/12/15 report, treater states "Continue to request lumbar brace to decrease back pain and spasm." Regarding lumbar supports, the MTUS/ACOEM guidelines are opposite of the ODG guidelines. ACOEM does not recommend supports for treatment, but do recommend them for prevention. ODG guidelines state they are not recommended for prevention, but recommended for treatment, specifically for spondylolisthesis with documented instability as in this case. California Labor Code section 4610.5 for medical necessity, describes a hierarchy of review standards. According to this, the MTUS/ACOEM guidelines take precedence over ODG guidelines. MTUS/ACOEM states that corsets are not recommended for treatment, and they are only beneficial in the acute phase of care. The request for Lumbar brace purchase is not medically necessary.

8 chiropractic manipulation visits: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual Therapy and Manipulation Page(s): 58-59.

Decision rationale: The patient presents with low to mid back pain. The request is for 8 Chiropractic Manipulation Visits. There is no RFA provided and the date of injury is 10/08/02.

The diagnoses include right knee arthroscopy with lateral meniscectomy and major synovectomy (5/03); bilateral open reduction internal fixation for bilateral femur fracture (2012); bilateral knee chondromalacia; lumbar spine sprain/ strain with disc protrusion, L5-S1; paraplegia following spinal surgery (9/13/07). Per 02/12/15, physical examination revealed no active motion of the lower extremities. There is severe atrophy of the bilateral low extremities with right greater than left. The patient is permanent and stationary. MTUS Manual Therapy and Manipulation guidelines pages 58, 59 state that treatment is "recommended for chronic pain if caused by musculoskeletal conditions... Ankle & Foot: Not recommended. Carpal tunnel syndrome: Not recommended. Forearm, Wrist, & Hand: Not recommended. Knee: Not recommended." MTUS recommends an optional trial of 6 visits over 2 weeks with evidence of objective functional improvement total of up to 18 visits over 6 to 8 weeks. For recurrences/flare-ups, reevaluate treatment success and if return to work is achieved, then 1 to 2 visits every 4 to 6 months. MTUS page 8 also requires that the treater monitor the treatment progress to determine appropriate course of treatments. For manual therapy, the MTUS guidelines on page 59 states, "Delphi recommendations in effect incorporate two trials, with a total of up to 12 trial visits with a re-evaluation in the middle, before also continuing up to 12 more visits (for a total of up to 24)." Per 02/12/15 report, treater states "Continue to request chiropractic therapy to decrease back pain and spasm." There is no documentation of prior chiropractic therapy for the patient. In this case, a short course of chiropractic therapy would be indicated, however MTUS recommends a trial of 6 visits with evidence of objective functional improvement. The request exceeds MTUS guidelines and therefore, is not medically necessary.

One Art meds 4 unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS in chronic intractable pain Page(s): 114-116. Decision based on Non-MTUS Citation Official disability guidelines Neck and Upper Back (Acute & Chronic) Chapter under Electrical muscle stimulation (EMS).

Decision rationale: The patient presents with low to mid back pain. The request is for One Art Meds 4 unit. There is no RFA provided and the date of injury is 10/08/02. The diagnoses include right knee arthroscopy with lateral meniscectomy and major synovectomy (5/03); bilateral open reduction internal fixation for bilateral femur fracture (2012); bilateral knee chondromalacia; lumbar spine sprain/ strain with disc protrusion, L5-S1; paraplegia following spinal surgery (9/13/07). Per 02/12/15, physical examination revealed no active motion of the lower extremities. There is severe atrophy of the bilateral low extremities with right greater than left. The patient is permanent and stationary. According to MTUS guidelines on the criteria for the use of TENS in chronic intractable pain:(p114-116) "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." ODG-TWC, Neck and Upper Back (Acute & Chronic) Chapter under Electrical muscle stimulation (EMS) states: "Not recommended. The current evidence on EMS is either lacking, limited, or conflicting. There is limited evidence of no benefit

from electric muscle stimulation compared to a sham control for pain in chronic mechanical neck disorders (MND). Most characteristics of EMS are comparable to TENS. The critical difference is in the intensity, which leads to additional muscle contractions..... In general, it would not be advisable to use these modalities beyond 2-3 weeks if signs of objective progress towards functional restoration are not demonstrated. (Kjellman, 1999)" Per 02/12/15 report, treater requests for "ART-meds 4 unit for pain. Patient prefers to not take meds) May help with prevention of further atrophy." While MTUS does recommend a 30 day trial of TENS, the request is for a dual unit, of which EMS or electrical muscle stimulator, also known as NMES is specifically not recommended for chronic pain. The request does not meet guideline indications, therefore TENS /EMS is not medically necessary.