

<b>Case Number:</b>	CM15-0055975		
<b>Date Assigned:</b>	04/01/2015	<b>Date of Injury:</b>	12/07/2001
<b>Decision Date:</b>	05/04/2015	<b>UR Denial Date:</b>	02/28/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/24/2015

### 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 54 year old male, who sustained an industrial injury on 12/7/2001. He reported getting out of his vehicle and feeling a pop in his lower back, developing pain in his neck area as well. Diagnoses have included chronic severe low back pain, bilateral sacroiliitis, left lower extremity acute radiculopathy and disc protrusion at L1- 2 with L2 nerve impingement. Treatment to date has included cervical spine fusion, right and left shoulder arthroscopy, lumbar fusion, physical therapy, chiropractic treatment and medication. According to the Primary Treating Physician's Progress Report dated 1/19/2015, the injured worker complained of ongoing constant neck pain rated 6/10 and constant low back pain rated 8-9/10. He also reported a significant amount of upper and lower extremity radiculopathy with numbness and tingling. He complained of spasms and weakness in the bilateral lower extremities. He also complained of constant, bilateral hip pain, and constant knee pain. Physical exam revealed that straight leg raise, Braggard's and bowstring tests were all positive bilaterally. The treatment plan was for land physical therapy consisting of range of motion and strengthening of the neck and low back, electromyography (EMG)/nerve conduction velocity (NCV) and for follow-up for medications. Authorization was requested for eight sessions of physical therapy, one set of x-rays of the lumbar spine, one Transcutaneous Electrical Nerve Stimulation (TENS) unit and one follow-up visit with a physiatrist.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**8 sessions of physical therapy:** Upheld

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

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

**Decision rationale:** Based on the 02/11/15 progress report provided by treating physician, the patient presents with low back and bilateral hip pain rated 8-9/10 that radiates to the bilateral lower extremities with associated numbness and tingling. Patient also complains of neck pain and bilateral knee pain. The request is for 8 SESSIONS OF PHYSICAL THERAPY. RFA not provided. Patient is status post spinal fusion L2-L4 with residual pain on 08/24/11, L5-S1 neurotomy, total disc replacement at L2-L3, total hip replacement and decompression 02/21/08, and right knee arthroscopy in 2006. Patient's diagnosis on 02/11/15 included failed back surgery syndrome with scar dysesthesia and neuropathic pain, chronic pain syndrome with severe breakthrough pain, chronic severe low back pain, neuropathic pain in the lower extremities, local neuropathic pain in the lumbar spine, bilateral sacroiliitis, and osteoarthritis of the bilateral knees. Physical examination to the lumbar spine on 02/11/15 revealed decreased range of motion, especially on extension 15 degrees. Range of motion of the hips decreased by 50%. Positive Kemp's, Fabere's, Gaellen's and sacroiliac compression tests bilaterally. Treatment to date included surgeries, physical therapy, chiropractic treatment and medications. Patient's medications include Percocet, Soma, Lyrica and Senokot. Per AME report dated 01/08/15, AME report dated 10/02/12 indicates patient was considered MMI, maximum medical benefit, having been temporarily and totally disabled since 2001. MTUS Chronic Pain Management Guidelines, pages 98, 99 has the following: "Physical Medicine: recommended as indicated below. Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine." MTUS guidelines pages 98, 99 states that for "Myalgia and myositis, 9-10 visits are recommended over 8 weeks. For Neuralgia, neuritis, and radiculitis, 8-10 visits are recommended. Treater has not provided reason for the request, nor a precise treatment history. Given the patient's diagnosis, continued symptoms, a short course of physical therapy would be indicated by guidelines. However, UR letter states "patient had undergone 27 physical therapy sessions..." In this case, treater does not discuss any flare-ups, does not explain why on-going therapy is needed, nor reason why patient is unable to transition into a home exercise program. Furthermore, the request for an additional 8 sessions would exceed what is allowed by MTUS. Therefore, the request IS NOT medically necessary.

**One (1) set of x-rays of the lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305. Decision based on Non-MTUS Citation Official disability guidelines Low back Chapter, Radiography.

**Decision rationale:** Based on the 02/11/15 progress report provided by treating physician, the patient presents with low back and bilateral hip pain rated 8-9/10 that radiates to the bilateral lower extremities with associated numbness and tingling. The request is for ONE (1) SET OF X-RAYS OF THE LUMBAR SPINE. RFA not provided. Patient is status post spinal fusion L2-L4 with residual pain on 08/24/11, L5-S1 neurotomy, and total disc replacement at L2-L3. Patient's diagnosis on 02/11/15 included failed back surgery syndrome with scar dysesthesia and neuropathic pain, chronic pain syndrome with severe breakthrough pain, chronic severe low back pain, neuropathic pain in the lower extremities, local neuropathic pain in the lumbar spine, bilateral sacroiliitis, and osteoarthritis of the bilateral knees. Patient's medications include Percocet, Soma, Lyrica and Senokot. Per AME report dated 01/08/15, AME report dated 10/02/12 indicates patient was considered MMI, maximum medical benefit, having been temporarily and totally disabled since 2001. MTUS/ACOEM Practice Guidelines, 2nd Edition (2004), Chapter 12 Low Back Complaints under Special Studies and Diagnostic and Treatment Considerations, pg 303-305 states "Lumbar spine x rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least six weeks." ODG-TWC, Low back Chapter under Radiography states: "Lumbar spine radiography should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least 6 weeks." ODG further states "Immediate imaging is recommended for patients with major risk factors for cancer, spinal infection, caudal equine syndrome, or severe or progressive neurologic deficits. Imaging after a trial of treatment is recommended for patients who have minor risk factors for cancer, inflammatory back disease, vertebral compression fracture, radiculopathy, or symptomatic spinal stenosis. Subsequent imaging should be based on new symptoms or changes in current symptoms." Treater has not provided reason for the request. There are no specific concerns for fracture, trauma, suspicion of cancer, and infection. Although the review of the reports do not show a recent or prior X-rays, the treater does not explain why X-rays are being asked. There are no specific concerns raised to warrant a set of X-rays. Therefore, the request IS NOT medically necessary.

**One (1) TENS unit:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS in chronic intractable pain Page(s): 114-116.

**Decision rationale:** Based on the 02/11/15 progress report provided by treating physician, the patient presents with low back and bilateral hip pain rated 8-9/10 that radiates to the bilateral lower extremities with associated numbness and tingling. Patient also complains of neck pain and bilateral knee pain. The request is for ONE (1) TENS UNIT. RFA not provided. Patient is status post spinal fusion L2-L4 with residual pain on 08/24/11, L5-S1 neurotomy, total disc

replacement at L2-L3, total hip replacement and decompression 02/21/08, and right knee arthroscopy in 2006. Patient's diagnosis on 02/11/15 included failed back surgery syndrome with scar dysesthesia and neuropathic pain, chronic pain syndrome with severe breakthrough pain, chronic severe low back pain, neuropathic pain in the lower extremities, local neuropathic pain in the lumbar spine, bilateral sacroiliitis, and osteoarthritis of the bilateral knees. Physical examination to the lumbar spine on 02/11/15 revealed decreased range of motion, especially on extension 15 degrees. Positive Kemp's, Fabere's, Gaellen's and sacroiliac compression tests bilaterally. Patient's medications include Percocet, Soma, Lyrica and Senokot. Per AME report dated 01/08/15, AME report dated 10/02/12 indicates patient was considered MMI, maximum medical benefit, having been temporarily and totally disabled since 2001. According to MTUS Chronic Pain Management Guidelines the criteria for use of TENS in chronic intractable pain (p116) "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." Treater has not provided reason for the request, indicated whether unit is for rental or home use, nor indicated what body part would be treated. UR letter dated 02/28/15 states "patient had tried and failed TENS treatments in the past." MTUS requires documentation of one month prior to dispensing home units with documentation of pain relief and function. Furthermore, the patient does not present with an indication for TENS unit. MTUS supports units for neuropathic pain, spasticity, MS, phantom pain and others. The request is not in accordance with guideline indications. Therefore, the request IS NOT medically necessary.