

<b>Case Number:</b>	CM15-0065113		
<b>Date Assigned:</b>	05/13/2015	<b>Date of Injury:</b>	05/06/2014
<b>Decision Date:</b>	07/07/2015	<b>UR Denial Date:</b>	03/17/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/06/2015

### 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: Utah, Arkansas  
 Certification(s)/Specialty: Family Practice, Sports 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 on May 6, 2014. He reported low back pain, mid back pain, neck pain and right long finger pain. The injured worker was diagnosed as having cervical spine disc bulges, thoracic spine disc bulges, lumbar spine strain and right long finger strain. Treatment to date has included diagnostic studies, physical therapy, medications and work restrictions. Currently, the injured worker complains of low back pain, mid back pain, neck pain and right long finger pain with associated loss of sleep. The injured worker reported an industrial injury in 2014, resulting in the above noted pain. He was treated conservatively without complete resolution of the pain. Evaluation on January 30, 2015, revealed continued pain as noted. He reported working light duty full time. Physiotherapy and medications were continued. A sleep study, a second surgical consultation for the right long finger, physical therapy and magnetic resonance imaging of the back and pelvis were recommended. Radiographic image of the lumbar spine on February 2, 2015, revealed no fracture or contusion, no foraminal stenosis and bulging discs between lumbar 3-5. TENS unit, a surgical consultation for the right long finger, a pain management consultation, a sleep study and a magnetic resonance image of the lumbar spine was requested.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI of the lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303, Postsurgical Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Chapter 12, Low Back Pain, Page 305.

**Decision rationale:** MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for MRI of the back. MTUS guidelines state the following: Despite the lack of strong medical evidence supporting it, diskography, including MRI, is fairly common, and when considered, it should be reserved only for patients who meet the following criteria: Back pain of at least three months duration. Failure of conservative treatment. Satisfactory results from detailed psychosocial assessment. (Diskography in subjects with emotional and chronic pain problems has been linked to reports of significant back pain for prolonged periods after injection, and therefore should be avoided.) Is a candidate for surgery. Has been briefed on potential risks and benefits from diskography and surgery. The patient has stated that he does not want surgery. There is also lack of clinical documentation of any neurological deficits. There were also no specific function deficits that were described. The clinical documents lack documentation that the patient has met the criteria. According to the clinical documentation provided and current MTUS guidelines, MRI, as written above, is not medically necessary to the patient at this time.

**TENS unit:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS, chronic pain (transcutaneous electrical nerve stimulation).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines TENS Unit, page(s) 113-115.

**Decision rationale:** MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for TENS unit. MTUS guidelines state the following: Not recommended as a primary treatment modality. While TENS may reflect the long standing accepted standard of care within many medical communities, the results of studies are inconclusive, the published trials do not provide parameters, which are most likely to provide optimum pain relief, nor do they answer questions about long-term effectiveness. Several studies have found evidence lacking concerning effectiveness. A one-month trial may be considered for condition of neuropathic pain and CRPS, phantom limb, multiple sclerosis and for the management of spasticity in a spinal cord injury. The patient does not meet the diagnostic criteria at this time. According to the clinical documentation provided and current MTUS guidelines, A TENS unit is not a medically necessary to the patient at this time.

**Pain management consult:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Chronic Pain Disorder Medical Treatment Guidelines, State of Colorado Department of Labor and Employment, page 56.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines General Approach to Initial Assessment and Documentation, page 22, Independent Medical Examinations and Consultations, chapter 7.

**Decision rationale:** MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for pain specialist consultation. MTUS guidelines state the following: consultation is indicated, when there are "red flag" findings. Also, to aid in the diagnosis, prognosis, therapeutic management, and determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work. The clinical documents lack documentation that state that the patient has neurological defects, which would warrant a referral. Clinical documents state that conservative treatment is helping improve pain levels. According to the clinical documentation provided and current MTUS guidelines, pain specialist consultation is not medically necessary to the patient at this time.

**Sleep study:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Pain (Chronic), Polysomnography.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines General Approach to Initial Assessment and Documentation, page 22, Independent Medical Examinations and Consultations, chapter 7.

**Decision rationale:** MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for sleep study consultation. MTUS guidelines state the following: consultation is indicated, when there are "red flag" findings. Also, to aid in the diagnosis, prognosis, therapeutic management, and determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work. The clinical documents lack documentation that state that the patient has clinical insomnia or deficits, which would warrant a referral. According to the clinical documentation provided and current MTUS guidelines, sleep study consultation is not medically necessary to the patient at this time.

**Referral to orthopedic surgeon for right long finger:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 11 Forearm, Wrist, and Hand Complaints Page(s): 254, 270.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines General Approach to Initial Assessment and Documentation, page 22, Independent Medical Examinations and Consultations, chapter 7.

**Decision rationale:** MTUS treatment guidelines were reviewed in regards to this specific case, and the clinical documents were reviewed. The request is for orthopedic consultation. MTUS guidelines state the following: consultation is indicated, when there are "red flag" findings. Also, to aid in the diagnosis, prognosis, therapeutic management, and determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work. The clinical documents lack documentation that states that the patient has any limitation function that could be improved by surgery. According to the clinical documentation provided and current MTUS guidelines, orthopedic consultation is not medically necessary to the patient at this time.