

<b>Case Number:</b>	CM15-0082606		
<b>Date Assigned:</b>	05/05/2015	<b>Date of Injury:</b>	06/18/2014
<b>Decision Date:</b>	09/02/2015	<b>UR Denial Date:</b>	04/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/29/2015

### 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: New York

Certification(s)/Specialty: Internal 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 54 year old female who sustained an industrial injury on June 18, 2014. She has reported mid to low back pain as well as left lower extremity pain and has been diagnosed with acute and chronic lumbar pain, lumbar osteoarthritis, spinal stenosis, degenerative disc disease, and left S1 joint strain. Treatment has included medications, medical imaging, modified work duty, injection, and physical therapy. Currently the injured worker complains of tenderness to palpation of the spine and extremities. Reflex testing of the upper and lower extremity were present bilaterally. There was decreased lumbar range of motion. The treatment request included MRI SI joints, physical therapy, tilt table, massage, CT guided epidural steroid injection, and neurosurgery August.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI (magnetic resonance imaging) SI (sacroiliac) Joints (unspecified): Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304, table 12-1, 12-8.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304-309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter--Magnetic resonance imaging (MRI).

**Decision rationale:** As per Official Disability Guidelines (ODG) - MRI (magnetic resonance imaging) is indicated for Lumbar spine trauma: trauma, neurological deficit, Thoracic spine trauma: with neurological deficit, Lumbar spine trauma: seat belt (chance) fracture (If focal, radicular findings or other neurologic deficit), Uncomplicated low back pain, suspicion of cancer, infection, other red flags. Uncomplicated low back pain, with radiculopathy, after at least 1 month conservative therapy, sooner if severe or progressive neurologic deficit, Uncomplicated low back pain, prior lumbar surgery, Uncomplicated low back pain, cauda equina syndrome, Myelopathy (neurological deficit related to the spinal cord), traumatic Myelopathy, painful Myelopathy, sudden onset, Myelopathy, stepwise progressive, Myelopathy, slowly progressive, Myelopathy, infectious disease patient, Myelopathy, oncology patient. Repeat MRI: When there is significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation). As per progress notes in the Medical Records, the injured worker does not appear to have significant changes in symptoms and signs, and the treating provider notes no changes in neurological exam, and there are no red flags. Therefore, the request for MRI (magnetic resonance imaging) SI (sacroiliac) Joints is not medically necessary and appropriate.

**Physical Therapy (unspecified):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines: Physical Therapy Guidelines.

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

**Decision rationale:** The prescription for Physical Therapy is evaluated in light of the MTUS recommendations for Physical Therapy. MTUS recommends 1) Passive therapy (those treatment modalities that do not require energy expenditure on the part of the patient) can provide short term relief during the early phases of pain treatment and are directed at controlling symptoms such as pain, inflammation and swelling and to improve the rate of healing soft tissue injuries. They can be used sparingly with active therapies to help control swelling, pain and inflammation during the rehabilitation process. 2) Active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. Active therapy requires an internal effort by the individual to complete a specific exercise or task. This form of therapy may require supervision from a therapist or medical provider such as verbal, visual and/or tactile instruction(s). Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Home exercise can include exercise with or without mechanical assistance or resistance and functional activities with assistive devices. The records indicate the injured worker had no functional benefit from prior physical therapy visits. Also there is no mention of any significant change of symptoms or clinical findings, or acute

flare up to support PT. The request does not specify for what body parts it is requested. The request for physical therapy is not medically necessary and appropriate.

**Tilt table:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Page(s): table 12-8. Decision based on Non-MTUS Citation Official Disability Guidelines: Lumbar traction.

**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--Traction and Other Medical Treatment Guidelines <http://www.mayoclinic.org/diseases-conditions/back-pain/expert-answers/inversion-therapy/faq-20057951>.

**Decision rationale:** Traction is not recommended using powered traction devices, but home-based patient controlled gravity traction may be a noninvasive conservative option, if used as an adjunct to a program of evidence-based conservative care to achieve functional restoration. As a sole treatment, traction has not been proved effective for lasting relief in the treatment of low back pain. Traction is the use of force that separates the joint surfaces and elongates the surrounding soft tissues. The evidence suggests that any form of traction may not be effective. Neither continuous nor intermittent traction by itself was more effective in improving pain, disability or work absence than placebo, sham or other treatments for patients with a mixed duration of LBP, with or without sciatica. There was moderate evidence that auto traction (patient controlled) was more effective than mechanical traction (motorized pulley) for global improvement in this population. Traction has not been shown to improve symptoms for patients with or without sciatica. Inversion therapy doesn't provide lasting relief from back pain, and it's not safe for everyone. Inversion therapy involves hanging upside down, and the head-down position could be risky for anyone with high blood pressure, heart disease or glaucoma. In theory, inversion therapy takes gravitational pressure off the nerve roots and disks in your spine and increases the space between vertebrae. Inversion therapy is one example of the many ways in which stretching the spine (spinal traction) has been used in an attempt to relieve back pain. Well-designed studies evaluating spinal traction have found the technique ineffective for long-term relief. However, some people find traction temporarily helpful as part of a more comprehensive treatment program for lower back pain caused by spinal disk compression. Within the submitted information and per guidelines the requested treatment: Tilt table is not medically necessary and appropriate.

**Massage (unspecified):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Massage therapy Page(s): 60.

**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--Massage therapy.

**Decision rationale:** Massage is a passive intervention and is considered an adjunct to other recommended treatment especially active interventions (e.g. exercise). Scientific studies show contradictory results. Furthermore, many studies lack long-term follow-up. Massage is beneficial in attenuating diffuse musculoskeletal symptoms, but beneficial effects were registered only during treatment. This lack of long-term benefits could be due to the short treatment period or treatments such as these do not address the underlying causes of pain. Recommended frequency and duration of treatment: (a) Time to Produce Effect: Immediate. (b) Frequency: 1 to 2 times per week. (c) Optimum Duration: 6 weeks. Maximum Duration: 2 months. (Colorado, 2006) At 2 months, patients should be reevaluated. Care beyond 2 months may be indicated for certain chronic pain patients in whom massage is helpful in improving function, decreasing pain, and improving quality of life. In these cases, treatment may be continued at 1 treatment every other week until the patient has reached MMI and maintenance treatments have been determined. Extended durations of care beyond what is considered maximum may be necessary in cases of re-injury, interrupted continuity of care, exacerbation of symptoms, and in those patients with comorbidities. Such care should be re-evaluated and documented on a monthly basis. Treatment beyond 2 months should be documented with objective improvement in function. Palliative care should be reevaluated and documented at each treatment session. Injured workers with complicating factors may need more treatment, if functional improvement is documented by the treating physician. The records indicate the injured worker had no functional benefit from prior passive therapy. Also there is no mention of any significant change of symptoms or clinical findings, or acute flare up to support massage therapy. The request does not specify for what body parts it is requested, and also there is no mention of duration and frequency. Medical necessity of the requested item has not been established.

**CT (computed tomography) guided ESI (epidural steroid injection) (unspecified):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Epidural steroid injections (ESIs).

**Decision rationale:** This requested treatment for Epidural steroid injections (ESIs) is evaluated in light of the CA MTUS and the Official Disability Guidelines (ODG) recommendations. As per MTUS most current guidelines recommend no more than 2 ESI injections. This is in contradiction to previous generally cited recommendations for a series of three ESIs. These early recommendations were primarily based on anecdotal evidence. Research has now shown that, on average, less than two injections are required for a successful ESI outcome. Current recommendations suggest a second epidural injection if partial success is produced with the first injection and a third ESI is rarely recommended. Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing home exercise program. There is little information on improved function. The American Academy of Neurology recently concluded that there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain. No more than two nerve root levels should be injected using transforaminal blocks. No more than one interlaminar level

should be injected at one session. In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. Review of medical documentation does not specify neurological deficits within a dermatomal pattern. The notes from treating provider do not indicate abnormal neurological exam. There is no evidence of nerve entrapment or radiculopathy. The injured worker had epidural steroid injection on 10/31/2014 that resulted in complete relief of pain, but the documentation is not clear about any functional benefit and reduction of medication use. The request does not specify site and frequency. Based on the cited guidelines and the submitted documentation, the request for ESI (epidural steroid injection) is not medically necessary.

**Neurosurgery - August:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-306.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Pain Chapter Office visits.

**Decision rationale:** Official Disability Guidelines (ODG) recommends office visits as determined to be medically necessary. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. As patient conditions are extremely varied, a set number of office visits per condition cannot be reasonably established. The determination of necessity for an office visit requires individualized case review and assessment. Medical records are not clear about any change in injured worker's chronic symptoms. The notes submitted by treating provider do not give details for the need of this request. Given the lack of documentation and considering the given guidelines, the request is not medically necessary.