

Case Number:	CM14-0114627		
Date Assigned:	08/04/2014	Date of Injury:	03/22/2002
Decision Date:	09/26/2014	UR Denial Date:	06/30/2014
Priority:	Standard	Application Received:	07/21/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Illinois. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 66-year-old male with a reported date of injury on 03/22/2002. The injury reportedly occurred when the injured worker fell approximately 4.5 feet. His diagnoses were noted to include cervical spine disc protrusion, lumbar spine disc protrusion, and annular tear. His previous treatments were noted to include medications, a TENS unit, physical therapy with electrical stimulation, ultrasound, massage, hot packs, and acupuncture. The progress note dated 07/03/2013 revealed complaints of neck pain rated 8/10 that radiated to the left shoulder and was associated with weakness. The injured worker complained of lower back pain rated 8/10 which radiated to both legs associated with tingling and weakness. The physical examination noted a decreased range of motion to the cervical spine. There was tenderness over the lumbar spine with a limited range of motion. The orthopedic tests for the lumbar spine were positive. The neurological examination revealed normal strength in the upper and lower extremities. There was a grade 4+/5 weakness in the left lower extremity. Sensation was reduced in the right upper and lower extremities. The Request for Authorization form was not submitted within the medical records. The request was for physical therapy 2 times a week x12 weeks, chiropractic treatment 2 times a week x12 weeks, computerized range of motion and muscle testing, heating pad, interferential (IF) unit, lumbar spine support, a neck pillow, naproxen 550 mg #90, and Norco 5/325 mg #50; however, the provider's rationale was not supported within the medical records.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical Therapy two (2) times a week times twelve (12) weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation ACOEM Guidelines 2007 Low Back Chapter (text, page 134).

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

Decision rationale: The injured worker has attended previous physical therapy sessions. The MTUS Chronic Pain Guidelines recommend active therapy 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. Injured workers 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 guidelines recommend for myalgia and myositis 9 to 10 visits over 8 weeks. There is a lack of documentation regarding current measurable functional deficits and quantifiable objective functional improvements with previous physical therapy sessions. There is a lack of documentation regarding the number of physical therapy sessions completed and the request for 24 sessions of physical therapy exceed guideline recommendations. Therefore, the request is not medically necessary.

Chiropractic treatment two (2) times a week times twelve (12) weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Postsurgical Treatment Guidelines. Decision based on Non-MTUS Citation ACOEM Guidelines 2007 Low Back Chapter (text, page 134).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manipulation therapy manipulation Page(s): 58.

Decision rationale: The MTUS Chronic Pain Guidelines recommend manual therapy and manipulation for chronic pain if caused by musculoskeletal conditions. Manual therapy is widely used in the treatment of musculoskeletal pain. The intended goal or effect of manual medicine is the achievement of positive, symptomatic, or objective measurable gains in functional improvement that facilitate progression in the injured worker's therapeutic exercise program and return to productive activities. The guidelines recommend for low back, a trial of 6 visits over 2 weeks, and with evidence of objective functional improvement, and a total of up to 18 visits over 6 to 8 weeks. There is a lack of documentation regarding current measurable functional deficits, as well as quantifiable objective functional improvements with previous physical therapy sessions. Additionally, the request for 24 sessions of chiropractic treatment exceeds guideline recommendations. Therefore, the request is not medically necessary.

Computerized Range of Motion (ROM) and muscle testing: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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, Flexibility.

Decision rationale: The Official Disability Guidelines do not recommend flexibility as a primary criterion, but should be a part of a routine musculoskeletal evaluation. The relation between lumbar range of motion measures and functional ability is weak or nonexistent. The guidelines do not recommend computerized measures of lumbar spine range of motion, which can be done with inclinometers, and where the result (range of motion) is of unclear therapeutic value. Measurements of 3 dimensional real time lower spine motion including derivatives of velocity and acceleration has greater utility in detecting injured workers with low back disorders in range of motion. The guidelines do not recommend computerized range of motion, and the preference is for an inclinometer. Therefore, the request is not medically necessary.

Heating Pad: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

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, Heat therapy.

Decision rationale: The ODG recommend heat therapy as an option. A number of studies show continuous low level heat wrap therapy to be effective for treating low back pain. Combining continuous low level heat wrap therapy with exercise during the treatment of acute low back pain significantly improves functional outcomes compared with either intervention alone or controlled. There is moderate evidence that heat wrap therapy provides a small short term reduction in pain and disability and acute and subacute low back pain, and that the addition of exercise further reduces pain and improves function. Heat therapy has been found to be helpful for pain reduction and return to normal function. There is a lack of documentation regarding the injured worker to utilize exercise in adjunct with the heat therapy. The previous request for physical therapy and chiropractic treatment have been deemed not medically necessary, and without documentation of exercise to be used as an adjunct to be used with heat therapy, a heating pad is not medically warranted. Therefore, the request is not medically necessary.

Interferential (IF) Unit: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118-119.

Decision rationale: The MTUS Chronic Pain Guidelines do not recommend interferential current stimulation as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with the recommended treatments, including return to work, exercise, and medications, and limited evidence of improvement on those recommended treatments alone. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue, shoulder pain, cervical neck pain, and postoperative knee pain. The guidelines criteria for interferential stimulation is pain is ineffectively controlled due to diminished effectiveness of medications, pain is ineffectively controlled due to side effects, history of substance abuse or significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment, or unresponsiveness to conservative measures. There is a lack of documentation regarding the failure of conservative treatment or exercise to be used as an adjunct to the interferential stimulation unit. Therefore, due to lack of documentation regarding failure of conservative treatment, exercise to be used as an adjunct to the interferential unit, an interferential unit is not appropriate at this time. Therefore, the request is not medically necessary.

Lumbar spine support: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): table 12-8. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (http://www.odg-twc.com/odgtwc/low_back.htm); ACOEM Guidelines (2007 revision, pages 138-139).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308.

Decision rationale: The ACOEM Guidelines do not recommend lumbar support for the treatment of low back disorders. The Guidelines state lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. The injured worker was injured 12 years ago initially, and therefore, is in a chronic phase of injury. The Guidelines recommend lumbar support for the acute phase of symptom relief. Therefore, the request is not medically necessary.

Neck pillow: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Neck and Upper back, pillow.

Decision rationale: The Official Disability Guidelines recommend the use of a neck support pillow while sleeping, in conjunction with daily exercise. This randomized controlled trial concluded that subjects with chronic neck pain should be treated by health professionals trained to teach both exercises and the appropriate use of neck support pillow during sleep; either strategy alone did not give the desired clinical benefit. The Guidelines recommend a neck pillow used in conjunction with daily exercise program and training by a health professional. The previous requests for physical therapy and chiropractic treatment were found not medically necessary and there is a lack of documentation regarding a home exercise program to be used as an adjunct to the neck pillow. Therefore, the request is not medically necessary.

Naproxyn 550mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs (non-steroidal anti-inflammatory drugs) Page(s): 67.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDs Page(s): 67-68.

Decision rationale: The MTUS Chronic Pain Guidelines recommend NSAIDs at the lowest dose for the shortest period in injured workers with moderate to severe pain. The MTUS Chronic Pain Guidelines state acetaminophen may be considered for initial therapy for injured workers with mild to moderate pain, and in particular, for those with gastrointestinal, cardiovascular, or renovascular risk factors. The MTUS Chronic Pain Guidelines recommend NSAIDs as a second line treatment after acetaminophen for acute exacerbations of chronic pain. In general, there is conflicting evidence that NSAIDs are more effective than acetaminophen for acute low back pain. The Guidelines recommend NSAIDs as an option for short term symptomatic relief. A review of literature on the drug relief for low back pain, suggested that NSAIDs were no more effective than other drugs such as acetaminophen, narcotic analgesics, and muscle relaxants. There is a lack of documentation regarding efficacy and improved functional status with the utilization of this medication. Additionally, the request failed to provide the frequency at which this medication is to be utilized. Therefore, the request is not medically necessary.

Norco 5/325mg #50: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, On-going Management Page(s): 78.

Decision rationale: According to the MTUS Chronic Pain Guidelines, the ongoing use of opioid medications may be supported with detailed documentation of pain relief, functional status, appropriate medication use, and side effects. The MTUS Chronic Pain Guidelines also state that the 4 A's for ongoing monitoring, including analgesia, activities of daily living, adverse side effects, and aberrant drug taking behaviors, should be addressed. There is a lack of

documentation regarding evidence of decreased pain on a numerical scale with medications. There is a lack of documentation regarding improved functional status with regards to activities of daily living with the use of medications. There is lack of documentation regarding side effects. There is lack of documentation whether the injured worker has had consistent urine drug screens and when the last test was performed. There was not a recent, adequate, and complete assessment submitted within the medical records. Additionally, the request failed to provide the frequency at which this medication is to be utilized. Therefore, the request is not medically necessary.