

Case Number:	CM14-0213778		
Date Assigned:	12/31/2014	Date of Injury:	06/13/2002
Decision Date:	03/03/2015	UR Denial Date:	12/02/2014
Priority:	Standard	Application Received:	12/22/2014

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. 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: 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 patient is an injured worker with a history of chronic low back pain. Date of injury was June 13, 2002. The progress report dated October 30, 2014 documented that the patient is an injured worker who suffers from chronic low back pain. The chief complaint was low back pain and spasms on the left side greater than the right and spasm. The patient denies any loss of bowel or bladder control, new weakness or change in the location of his pain. He is reporting a change in the intensity due to the reduction in medications, which are no longer working at the current levels. The patient was unable to get medications authorized for refill particularly his Percocet. The Percocet was not authorized for refill. The patient was able to continue his MS Contin. However, after about ten hours his pain level increases significantly and without the Percocet he was unable to control this pain and has missed work. He wishes to resume his previous doses of medications so that he can continue to work. Adverse effect on functional status, sleep and mood was noted. The patient reports that his quality of life prior to the reduction of medications was 4/5 and is now 2/5. His pain prior to the reduction of medicines was 3-4/10 and manageable where is it now 6/10 and interference with the ability to stay on the job. Physical examination was documented. The patient appears tired and he is exhibiting a furrowed brow. He appears depressed. On examination of the lumbar area there are large tender muscle bands with deep palpation that radiate in bilateral buttock. There is positive exquisite tenderness with deep palpation over the SI sacroiliac joints bilaterally. Deep tendon reflexes are 1+ at the knee and the ankle bilaterally. No ankle clonus was present. Motor exam is intact 4/5. Straight leg raising is negative. Sensation is grossly intact. Diagnoses included spasms with trigger points bilaterally to

the buttock and lumbar degenerative disc disease and spondylosis. The treatment plan included requests for MS Contin, Percocet, TENS transcutaneous electrical nerve stimulation, trigger point injections, lumbar MRI magnetic resonance imaging, and physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy for the lumbar spine twice a week for four weeks: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy (PT) Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic) Physical medicine treatment Official Disability Guidelines (ODG) Preface Physical Therapy Guidelines Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic) Physical therapy (PT).

Decision rationale: Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines provide physical therapy (PT) physical medicine guidelines. For myalgia and myositis, 9-10 visits are recommended. For neuralgia, neuritis, and radiculitis, 8-10 visits are recommended. Official Disability Guidelines (ODG) recommends 10 visits for lumbar sprains and strains. Per Medical Treatment Utilization Schedule (MTUS) definitions, functional improvement means either a clinically significant improvement in activities of daily living or a reduction in work restrictions, and a reduction in the dependency on continued medical treatment. Official Disability Guidelines (ODG) present physical therapy PT guidelines; Patients should be formally assessed after a six visit clinical trial to evaluate whether PT has resulted in positive impact, no impact, or negative impact prior to continuing with or modifying the physical therapy. When treatment duration and/or number of visits exceed the guideline, exceptional factors should be noted. Medical records document a history of chronic low back pain. The date of injury was June 13, 2002. No functional improvements with past PT physical therapy treatments were documented. Because function improvements with past PT treatments were not documented, the 10/30/14 request for PT physical therapy is not supported by MTUS or ODG guidelines. Therefore, the request for Physical therapy for the lumbar spine twice a week for four weeks is not medically necessary.

TENS unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, 308-310, Chronic Pain Treatment Guidelines Transcutaneous Electrotherapy; Electrical stimulators (E-stim) Page(s): 45; 114-121.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses transcutaneous electrotherapy. Several published evidence-based assessments of transcutaneous electrical nerve stimulation (TENS) have found that evidence is lacking concerning effectiveness. Interferential Current Stimulation (ICS) is not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications. Neuromuscular electrical stimulation (NMES devices) is not recommended. Electroceutical Therapy (bioelectric nerve block) is not recommended. Galvanic Stimulation is not recommended. Microcurrent electrical stimulation (MENS devices) is not recommended. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 12 Low Back Complaints (Page 300) states that physical modalities such as diathermy, ultrasound, transcutaneous electrical neurostimulation (TENS) units, percutaneous electrical nerve stimulation (PENS) units, and biofeedback have no proven efficacy in treating acute low back symptoms. Insufficient scientific testing exists to determine the effectiveness of these therapies. Table 12-8 Summary of Recommendations for Evaluating and Managing Low Back Complaints (Page 308) states that TENS is not recommended. Medical records document low back conditions. MTUS and ACOEM guidelines do not support the use of transcutaneous electrotherapy for low back conditions. Therefore, the request for a Prime Dual nerve stimulator transcutaneous electrical nerve stimulation electrical muscle stimulator unit is not supported by MTUS and ACOEM guidelines. Therefore, the request for TENS unit is not medically necessary.

Trigger point injections to the bilateral buttocks: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, 309, Chronic Pain Treatment Guidelines Trigger point injections Page(s): 122.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses trigger point injections. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 12 Low Back Complaints (Page 300) indicates that trigger-point injections are not recommended. Invasive techniques (e.g., local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit. Table 12-8 Summary of Recommendations for Evaluating and Managing Low Back Complaints (Page 309) indicates that trigger-point injections are not recommended. Medical records document low back conditions. ACOEM guidelines indicate that trigger point injections are not recommended for low back conditions. Therefore, the request for trigger point injections is not supported by ACOEM guidelines. Therefore, the request for Trigger point injections to the bilateral buttocks is not medically necessary.

Repeat MRI of the lumbar spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back, Lumbar and Thoracic chapter

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints
Page(s): 303-304, 308-310.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses magnetic resonance imaging MRI of the lumbosacral spine. American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 12 Low Back Complaints states that relying solely on imaging studies to evaluate the source of low back and related symptoms carries a significant risk of diagnostic confusion (false-positive test results). Table 12-8 Summary of Recommendations for Evaluating and Managing Low Back Complaints (Page 308-310) recommends MRI when cauda equina, tumor, infection, or fracture are strongly suspected and plain film radiographs are negative. The progress report dated October 30, 2014 does not document the results of plain film radiographs or previous MRI magnetic resonance imaging studies. No evidence of cauda equina, tumor, infection, or fracture was documented. The patient denied any loss of bowel or bladder control, new weakness or change in the location of his pain. The request for a repeat lumbar MRI magnetic resonance imaging is not supported by the MTUS guidelines. Therefore, the request for Repeat MRI of the lumbar spine is not medically necessary.