

Case Number:	CM15-0122744		
Date Assigned:	07/14/2015	Date of Injury:	03/28/2012
Decision Date:	09/24/2015	UR Denial Date:	06/12/2015
Priority:	Standard	Application Received:	06/25/2015

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: Texas, New York, California
 Certification(s)/Specialty: Preventive Medicine, Occupational 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 applicant is a represented 59-year-old who has filed a claim for chronic neck and low back pain reportedly associated with an industrial injury of March 28, 2012. In a Utilization Review report dated June 12, 2015, the claims administrator failed to approve requests for sacroiliac joint injection therapy, cervical epidural steroid injection therapy, a lumbar MRI, cervical collar, a TENS unit rental, and a P-STIM device. The claims administrator referenced an RFA form received on June 5, 2015 in its determination. The claims administrator did partially approved the request for 90-day TENS unit rental to 30-day rental of the same. The full text of the UR report was not seemingly attached to the application. On May 13, 2015, the applicant reported multifocal complaints of neck, arm, and low back pain, 8-9/10. The applicant reported complaints of low back pain radiating into the bilateral lower extremities, it was reported. The applicant also exhibited tenderness about the SI joints. The attending provider contended that the applicant had issues with both cervical and lumbar radiculopathy with corresponding radiographic findings on cervical and lumbar MRI imaging. 8/10 pain complaints were reported. The applicant's past medical history was noncontributory, it was stated. The applicant exhibited stiffness about the low back, hips, and knees. A mild limp was noted. Lower extremity strength ranging from 4-5/5 was reported. The attending provider referenced cervical MRI imaging of August 26, 2015 notable for mild spondylolysis at C4-C5 and C5-C6 and a 1-mm posterior disk bulge at C6-C7. The applicant was asked to pursue a cervical epidural steroid injection. Lumbar spine MRI imaging was sought. The applicant was also asked to employ a cervical collar, a TENS unit, Norco, and Neurontin. A percutaneous neurostimulator device was also sought. The

applicant's work status was not explicitly detailed, although it did not appear that the applicant was working.

IMR ISSUES, DECISIONS AND RATIONALES

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

1st Bilateral SI joint injection under fluoroscopic guidance: 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 ACOEM Occupational Medicine Practice Guidelines, 3rd ed., Low Back Disorders, pg. 611.

Decision rationale: No, the request for a sacroiliac joint injection was not medically necessary, medically appropriate, or indicated here. 1. Recommendation: Sacroiliac Joint Corticosteroid Injections for Treatment of Sacroiliitis. Sacroiliac joint corticosteroid injections are recommended as a treatment option for patients with a specific known cause of sacroiliitis, i.e., proven rheumatologic inflammatory arthritis involving the sacroiliac joints. Strength of Evidence- Recommended, Evidence (C). 2. Recommendation: Sacroiliac Joint Injections for Treatment of Low Back Pain Sacroiliac joint injections are not recommended for treatment of acute low back pain including low back pain thought to be sacroiliac joint related; subacute or chronic non-specific low back pain, including pain attributed to the sacroiliac joints, but without evidence of inflammatory sacroiliitis (rheumatologic disease); or any radicular pain syndrome. Strength of Evidence- Not Recommended, Insufficient Evidence (I). The MTUS does not address the topic. However, the Third Edition ACOEM Guidelines Chronic Pain Chapter notes that sacroiliac joint injections are not recommended for applicants with chronic nonspecific low back pain and/or applicants with radicular pain complaints, both of which were reportedly present on or around the date of the request, May 13, 2015. Rather, ACOEM suggests reserving SI joint injections for applicants with some rheumatologically-proven spondyloarthropathy implicating the sacroiliac joints. Here, however, there was no mention of the applicant's carrying a diagnosis of rheumatologically-proven spondyloarthropathy implicating the SI joints for which the SI joint injection in question was indicated. Therefore, the request was not medically necessary.

1st CESI at C7-T1, C6-C7: Upheld

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

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

Decision rationale: Similarly, the request for a cervical epidural steroid injection at C7-T1 and C6-C7 was likewise not medically necessary, medically appropriate, or indicated here. While page 46 of the MTUS Chronic Pain Medical Treatment Guidelines does acknowledge that epidural steroid injections are recommended as an option in the treatment of radicular pain, page 46 of the MTUS Chronic Pain Medical Treatment Guidelines qualifies its position by noting that radiculopathy should be corroborated by imaging studies and/or

electrodiagnostic testing. Here, however, the attending provider's May 13, 2015 progress note referenced earlier cervical MRI imaging demonstrated low-grade disk bulging at C6-C7 and mild spondylolisthesis at C4-C5 and C5-C6. It did not appear, thus, that the applicant had radiographic or electrodiagnostic corroboration of radiculopathy at the levels in question. Therefore, the request was not medically necessary.

Lumbar MRI: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 304.

Decision rationale: Similarly, the request for lumbar MRI imaging was likewise not medically necessary, medically appropriate, or indicated here. As noted in the MTUS Guideline in ACOEM Chapter 12, page 304, imaging studies should be reserved for cases in which surgery is being considered or red-flag diagnoses are being evaluated. Here, however, there was no mention of the applicant's actively considering or contemplating any kind of surgical intervention involving the lumbar spine based on the outcome of the study in question. The requesting provider was a pain management physician (as opposed to a spine surgeon), significantly reducing the likelihood of the applicant's acting on the results of the study in question. There was, in short, neither an explicit statement (nor an implicit expectation) that the applicant would act on the results of the study in question. Therefore, the request was not medically necessary.

Cervical Collar: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 181.

Decision rationale: Similarly, the request for a cervical collar was likewise not medically necessary, medically appropriate, or indicated here. As noted in the MTUS Guideline in ACOEM Chapter 8, Table 8-8, page 181, cervical collars are deemed "not recommended" for more than one or two days. Here, thus, the request for provision of a cervical collar at this late stage in the course of the claim, several years removed from the date of injury, thus, was at odds with ACOEM principles and parameters. Therefore, the request was not medically necessary.

TENS Unit rental for 90 days: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of TENS Page(s): 116.

Decision rationale: Similarly, the request for a TENS unit rental for 90 days was likewise not medically necessary, medically appropriate, or indicated here. While page 116 of the MTUS Chronic Pain Medical Treatment Guidelines does acknowledge that a one-month trial of the TENS unit can be employed in applicants with chronic intractable pain of greater than three months- duration in whom other appropriate pain modalities have been tried and/or failed, here, however, the applicant was described on May 13, 2015 as using a variety of unspecified pain medications and muscle relaxants. There was no mention of the applicant's having tried and/or failed analgesic medications on that date. Page 116 of the MTUS Chronic Pain Medical Treatment Guidelines also stipulates that a one-month trial of the TENS unit be considered. Here, thus, the request for a 90-day rental of the TENS unit was at odds with MTUS principles and parameters. Finally, page 116 of the MTUS Chronic Pain Medical Treatment Guidelines also stipulates that a TENS unit be employed in conjunction with a program of functional restoration. Here, the applicant's work and functional status were not clearly outlined as of the date of the request, May 13, 2015. Therefore, the request was not medically necessary.

P stim 1x4 under fluoroscopy guidance: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Percutaneous electrical nerve stimulation (PENS) Page(s): 97.

Decision rationale: Finally, the request for a P-STIM device was not medically necessary, medically appropriate, or indicated here. While page 97 of the MTUS Chronic Pain Medical Treatment Guidelines does acknowledge that a percutaneous electrical nerve stimulator device trial may be considered if used as an adjunct to a program of evidence-based functional restoration after other nonsurgical treatments, including therapy with exercise and a TENS unit, have been tried and/or failed or judged to be unsuitable are contraindicated, here, however, it did not appear that the applicant had in fact failed a TENS unit prior to the date in question. As with the preceding request, the applicant's work and functional status were not detailed or discussed. It did not appear, however, that the applicant was working or that the percutaneous electrical nerve stimulator was intended for use in conjunction with a program of evidence-based functional restoration. Therefore, the request was not medically necessary.