

Case Number:	CM15-0143701		
Date Assigned:	08/04/2015	Date of Injury:	06/09/2009
Decision Date:	10/13/2015	UR Denial Date:	07/10/2015
Priority:	Standard	Application Received:	07/24/2015

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: 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 injured worker is a 58 year old female who sustained an industrial injury on 06-09-2009. Mechanism of injury was not found in documents presented for review. Diagnoses include lumbar disc displacement, lumbar spine strain-sprain, and radicular syndrome of lower limbs. Treatment to date has included diagnostic studies, medications, trigger point injections, physical therapy, acupuncture, and epidural injections. On 06-18-2014, a Magnetic Resonance Imaging of the lumbar spine showed multiple areas of disc protrusion with mild narrowing of the neural foramen and mild to moderate spinal canal stenosis. The most recent physician progress note dated 04-27-2015 documents the injured worker complains of persistent lumbar spine pain that is sharp and leg pain that is dull. TPII results done on 06-17-2015 are consistent with lumbar spine and myofascial pain. There is a burning, cramping, numbness and pins and needles sensation. Discomfort is frequent and severe and there is radiation noted from the low back bilaterally. She has weakness of the muscles of the low back and bilateral legs. Treatment requested is for Epidural Injection Lumbar Spine L5-S1 on the left, Flexeril 10mg #15, Gaba/Flur Compound (dosage unspecified), Interferential Unit for home use (duration & frequency unspecified), Localized Intense Neurostimulation (LINT) Therapy 1 x 6 Lumbar Spine, Motrin 800mg (quantity unspecified), Norco 10/325mg (quantity unspecified), Physical Therapy 2 x 3, Prilosec 20mg (quantity unspecified), Retro (DOS 6/17/15, 6/23/15): Localized Intense Neurostimulation (LINT) x 2, and Retro (DOS 6/17/15, 6/23/15): Trigger Points Impedance Imaging x 2.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro (DOS 6/17/15, 6/23/15): Trigger Points Impedance Imaging x 2: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG): Trigger Point Impedance Imaging.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Trigger point injections.

Decision rationale: The MTUS states that trigger point injections are recommended only for myofascial pain syndrome with limited lasting value and not recommended for radicular pain. These injections may occasionally be necessary to maintain function in those with myofascial problems when myofascial trigger points are present on examination. Not recommended for typical back pain or neck pain. Retro (DOS 6/17/15, 6/23/15): Trigger Points Impedance Imaging x 2 is not medically necessary.

Retro (DOS 6/17/15, 6/23/15): Localized Intense Neurostimulation (LINT) x 2: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, and Shoulder Complaints 2004, and Elbow Complaints 2007, and Forearm, Wrist, and Hand Complaints 2004, and Low Back Complaints 2004, and Knee Complaints 2004, and Ankle and Foot Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Percutaneous Electrical Nerve Stimulation (PEN).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Percutaneous electrical nerve stimulation (PENS).

Decision rationale: Localized Intense Neurostimulation Therapy (LINT) is equivalent to Percutaneous Electrical Nerve Stimulation (PENS). The Official Disability Guidelines do not recommend percutaneous electrical nerve stimulation has a primary treatment modality. There is a lack of high quality evidence to prove long-term efficacy. A trial may be considered, if used as an adjunct to a program of evidence-based functional restoration, after other non-surgical treatments, including therapeutic exercise and TENS, have been tried and failed or are judged to be unsuitable or contraindicated. There is no documentation that LINT is to be used as an adjunct to a program of evidence-based functional restoration, after other non-surgical treatments, including therapeutic exercise and TENS, have been tried and failed or are judged to be unsuitable or contraindicated. Retro (DOS 6/17/15, 6/23/15): Localized Intense Neurostimulation (LINT) x 2 is not medically necessary.

Norco 10/325mg (quantity unspecified): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Opioids for chronic pain.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that continued or long-term use of opioids should be based on documented pain relief and functional improvement

or improved quality of life. Despite the long-term use of Norco, the patient has reported very little, if any, functional improvement or pain relief over the course of the last 6 months. A previous utilization review decision provided the patient with sufficient quantity of medication to be weaned slowly off of narcotic. Norco 10/325mg (quantity unspecified) is not medically necessary.

Prilosec 20mg (quantity unspecified): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs, GI symptoms & cardiovascular risk.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, prior to starting the patient on a proton pump inhibitor, physicians are asked to evaluate the patient and to determine if the patient is at risk for gastrointestinal events. Criteria used are: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID. There is no documentation that the patient has any of the risk factors needed to recommend the proton pump inhibitor omeprazole. Prilosec 20mg (quantity unspecified) is not medically necessary.

Motrin 800mg (quantity unspecified): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): NSAIDs (non-steroidal anti-inflammatory drugs).

Decision rationale: The MTUS recommends NSAIDs at the lowest dose for the shortest period in patients with moderate to severe pain. NSAIDs appear to be superior to acetaminophen, particularly for patients with moderate to severe pain. There is no evidence of long-term effectiveness for pain or function. The medical record contains no documentation of functional improvement. Motrin 800mg (quantity unspecified) is not medically necessary.

Flexeril 10mg #15: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Cyclobenzaprine (Flexeril).

Decision rationale: The MTUS Chronic Pain Treatment Guidelines do not recommend long-term use of muscle relaxants such as cyclobenzaprine. The patient has been taking Flexeril for an extended period, long past the 2-3 weeks recommended by the MTUS. The clinical information submitted for review fails to meet the evidence-based guidelines for the requested service. Flexeril 10mg #15 is not medically necessary.

Gaba/ Flur Compound (dosage unspecified): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Topical Analgesics.

Decision rationale: According to the MTUS, there is little to no research to support the use of many of these compounded topical analgesics. Any compounded product that contains at least one drug (or drug class) that is not recommended is not recommended. Gabapentin is not recommended. There is no peer-reviewed literature to support use. Gaba/Flur Compound (dosage unspecified) is not medically necessary.

Physical Therapy 2 x 3: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation.

Decision rationale: The MTUS Chronic Pain Medical Treatment Guidelines state that 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. Continued physical therapy is predicated upon demonstration of a functional improvement. The patient has been approved for an unknown number of treatments in the past. There is no documentation of objective functional improvement. Physical Therapy 2 x 3 is not medically necessary.

Epidural Injection Lumbar Spine L5-S1 on the left: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

Decision rationale: According to the MTUS, several diagnostic criteria must be present to recommend an epidural steroid injection. The most important criteria are that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 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. The medical record lacks sufficient documentation and does not support a referral request. Epidural Injection Lumbar Spine L5-S1 on the left is not medically necessary.

Localized Intense Neurostimulation (LINT) Therapy 1 x 6 Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS Neck and Upper Back Complaints 2004, and Shoulder Complaints 2004, and Elbow Complaints 2007, and Forearm, Wrist, and

Hand Complaints 2004, and Low Back Complaints 2004, and Knee Complaints 2004, and Ankle and Foot Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Percutaneous Electrical Nerve Stimulation (PENS).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain (Chronic), Percutaneous electrical nerve stimulation (PENS).

Decision rationale: Localized Intense Neurostimulation Therapy (LINT) is equivalent to Percutaneous Electrical Nerve Stimulation (PENS). The Official Disability Guidelines do not recommend percutaneous electrical nerve stimulation has a primary treatment modality. There is a lack of high quality evidence to prove long-term efficacy. A trial may be considered, if used as an adjunct to a program of evidence-based functional restoration, after other non-surgical treatments, including therapeutic exercise and TENS, have been tried and failed or are judged to be unsuitable or contraindicated. There is no documentation that LINT is to be used as an adjunct to a program of evidence-based functional restoration, after other non-surgical treatments, including therapeutic exercise and TENS, have been tried and failed or are judged to be unsuitable or contraindicated. Localized Intense Neurostimulation (LINT) Therapy 1 x 6 Lumbar Spine is not medically necessary.

Interferential Unit for home use (duration & frequency unspecified): Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004, and Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Transcutaneous electrotherapy.

Decision rationale: According to the MTUS an 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, and limited evidence of improvement on those recommended treatments alone. A TENS unit without interferential current stimulation is the recommended treatment by the MTUS. Interferential Unit for home use (duration & frequency unspecified) is not medically necessary.