MAXIMUS Federal Services

Case Number:	CM15-0070070		
Date Assigned:	04/17/2015	Date of Injury:	01/06/2014
Decision Date:	06/29/2015	UR Denial Date:	04/06/2015
Priority:	Standard	Application Received:	04/14/2015

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: Physical Medicine & Rehabilitation

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 41-year-old female, who sustained an industrial injury on January 6, 2014. She has reported lower back pain, right leg pain, and buttock pain. Diagnoses have included lumbar spine musculoligamentous injury with right lower extremity radiculitis, lumbosacral spondylolisthesis, and right lower extremity radiculopathy, and right sacroiliac joint sprain/strain. Treatment to date has included medications, lumbar support bracing, and imaging studies. The injured worker also underwent physical therapy and epidural steroid injection, neither of which was noted to offer any benefit. A progress note dated March 10, 2015 indicates a chief complaint of lower back pain, and right buttock pain with lower extremity pain. The treating physician documented a plan of care that included medications, transcutaneous electrical nerve stimulation unit rental, lumbar spine orthosis, and magnetic resonance imaging of the lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

One month rental of TENS unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS (transcutaneous electrical nerve stimulation).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 114-116.

Decision rationale: The patient was injured on 01/06/14 and presents with low back pain, right buttock pain, lower extremity pain, headaches, and stress. The request is for a ONE MONTH RENTAL OF TENS UNIT. The RFA is dated 03/10/15 and the patient is on temporary total disability. Per MTUS Guidelines page 116, TENS unit have not proven efficacy in treating chronic pain and is not recommend as a primary treatment modality, but a 1-month home-based trial may be considered for a specific diagnosis of neuropathy, CRPS, spasticity, a phantom limb pain, and multiple sclerosis. When a TENS unit is indicated, a 30-day home trial is recommended, and with the documentation of functional improvement, additional usage maybe indicated. There is tenderness to palpation with muscle spasm and guarding present over the bilateral paraspinal musculature, tenderness to palpation over the right sacroiliac joint, a positive Kemp's test eliciting right sacroiliac joint pain and increased low back pain, a positive straight leg raise on the right for radicular symptoms to the right lower extremity, a decreased lumbar spine range of motion, and decreased sensation on the right foot and toes. The patient is diagnosed with lumbar spine musculoligamentous injury with right lower extremity radiculitis, lumbosacral spondylolisthesis, right lower extremity radiculopathy, and right sacroiliac joint sprain/strain. Treatment to date includes medications, lumbar support bracing, and imaging studies. The treater is requesting for "TENS unit for continuous home treatment." Usage of TENS requires documentation of any pain relief, duration of relief, and improved function. It appears that the patient has been using the TENS unit for some time; however, there is no indication of how long the patient used this unit for, no evidence of a 1 month trial as indicated by MTUS guidelines, and no clear documentation of any benefit with the TENS. The details, history and efficacy of the prior TENS unit are unclear. Therefore, the requested one month rental of TENS unit IS NOT medically necessary.

One MRI scan of the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official disability guidelines low back chapter, MRI.

Decision rationale: The patient was injured on 01/06/14 and presents with low back pain, right buttock pain, lower extremity pain, headaches, and stress. The request is for ONE MRI SCAN OF THE LUMBAR SPINE in consideration of invasive treatment. The RFA is dated 03/10/15 and the patient is on temporary total disability. The 03/10/15 report states that the patient had a prior MRI of the lumbar spine on 08/12/14, which revealed lytic spondylolisthesis of L5 on S1 with bilateral pars defect and lower extremity radiculopathy. For special diagnostics, ACOEM Guidelines page 303 states, "Unequivocal and equivocal objective findings that identified specific nerve compromise on neurological examination or sufficient evidence to warrant imaging in patient who did not respond well to retreatment and who could consider surgery an

option. Neurological examination is less clear; however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study." ODG Guidelines on low back chapter MRI topics states that "MRIs are tests of choice for patients with prior back surgery, but for uncomplicated low back with radiculopathy, not recommended until at least 1 month of conservative care, sooner if severe or progressive neurologic deficit." There is tenderness to palpation with muscle spasm and guarding present over the bilateral paraspinal musculature, tenderness to palpation over the right sacroiliac joint, a positive Kemp's test eliciting right sacroiliac joint pain and increased low back pain, a positive straight leg raise on the right for radicular symptoms to the right lower extremity, a decreased lumbar spine range of motion, and decreased sensation on the right foot and toes. The patient is diagnosed with lumbar spine musculoligamentous injury with right lower extremity radiculitis, lumbosacral spondylolisthesis, right lower extremity radiculopathy, and right sacroiliac joint sprain/strain. Treatment to date includes medications, lumbar support bracing, and imaging studies. The patient had a prior MRI of the lumbar spine on 08/12/14. Review of the reports provided does not mention if the patient had a recent surgery or any recent therapy. Although the treater would like an update MRI of the lumbar spine prior to a surgery, there are no new injuries, no significant change on examination findings, no bowel/bladder symptoms, or new location of symptoms to warrant an updated MRI. Therefore, the requested repeat MRI of the lumbar spine IS NOT medically necessary.

One prescription of Ultram ER 150mg #30: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines criteria for use of opiates Page(s): 76-78, 88-89.

Decision rationale: The patient was injured on 01/06/14 and presents with low back pain, right buttock pain, lower extremity pain, headaches, and stress. The request is for ULTRAM ER 150 MG #30. The RFA is dated 03/10/15 and the patient is on temporary total disability. There is no indication of when the patient began taking this medication. There are two progress reports provided from 03/10/15 and 04/08/15. MTUS Chronic Pain Medical Treatment Guidelines pages 88-89, "criteria for use of opiates for long-term users of opiates (6 months or more)" states, "pain should be assessed at each visit, and functioning should be measured at 6-month intervals using a numerical scale or validated instrument." MTUS page 78 criteria for use of opiates, ongoing management also requires documentation of the 4 A's (analgesia, ADLs, adverse side effects, and adverse behavior), as well as "pain assessment" or outcome measures that include current pain, average pain, least pain, intensity of pain after taking the opioid, time it takes for medication to work, and duration of pain relief. In this case, none of the 4 A's are addressed as required by MTUS Guidelines. The treater does not provide any before-and-after pain scales. There are no examples of ADLs, which demonstrate medication efficacy, nor are there any discussions provided on adverse behavior/side effects. No validated instruments are used either. There is no pain management issues discussed such as urine drug screens, CURES report, pain contract, etc. No outcome measures are provided as required by MTUS Guidelines. The treating physician does not provide proper documentation that is required by MTUS Guidelines for continued opiate use. Therefore, the requested Ultram IS NOT medically necessary.

One lumbar support orthosis: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official disability guidelines low back chapter, lumbar supports.

Decision rationale: The patient was injured on 01/06/14 and presents with low back pain, right buttock pain, lower extremity pain, headaches, and stress. The request is for ONE LUMBAR SUPPORT ORTHOSIS. The RFA is dated 03/10/15 and the patient is on temporary total disability. ACOEM Guidelines page 301 on lumbar bracing states, "lumbar supports have not been shown to have any lasting benefit beyond the acute phase of the symptom relief." ODG Guidelines under its low back chapter, lumbar supports state, "prevention: Not recommended for prevention. There is strong inconsistent evidence that lumbar supports were not effective in preventing neck and back pain." Under treatment, ODG further states, "recommended as an option for compression fractures and specific treatments of spondylolisthesis, documented instability, and treatment for nonspecific LBP (very low quality evidence, but may be a conservative option)." There is tenderness to palpation with muscle spasm and guarding present over the bilateral paraspinal musculature, tenderness to palpation over the right sacroiliac joint, a positive Kemp's test eliciting right sacroiliac joint pain and increased low back pain, a positive straight leg raise on the right for radicular symptoms to the right lower extremity, a decreased lumbar spine range of motion, and decreased sensation on the right foot and toes. The patient is diagnosed with lumbar spine musculoligamentous injury with right lower extremity radiculitis, lumbosacral spondylolisthesis, right lower extremity radiculopathy, and right sacroiliac joint sprain/strain. In this case, the patient does present with lumbosacral spondylolisthesis as indicated by ODG guidelines. Therefore, the requested lumbar support orthosis IS medically necessary.