

Case Number:	CM15-0071119		
Date Assigned:	04/21/2015	Date of Injury:	12/11/2013
Decision Date:	07/09/2015	UR Denial Date:	04/07/2015
Priority:	Standard	Application Received:	04/15/2015

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: North Carolina, Georgia
 Certification(s)/Specialty: Family Practice

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 40 year old male, who sustained an industrial injury on December 11, 2013. The injured worker has been treated for mid and low back complaints. The diagnoses have included lumbar sprain/strain, lumbar paraspinal muscle spasms and thoracic spine sprain/strain. Treatment to date has included medications, radiological studies, chiropractic sessions, acupuncture treatment, physical therapy and a home exercise program. Current documentation dated March 18, 2015 notes that the injured worker reported moderate to severe mid back pain with muscle spasms. The pain radiated to both lower extremities with associated weakness, numbness and tingling. Examination of the spine revealed tenderness to palpation over the lumbar area, associated with severe myofascial pain and guarding. Range of motion was noted to be decreased. A straight leg raise test was severely positive bilaterally. The treating physician's plan of care included a request for an MRI of the thoracic spine, physical therapy, acupuncture treatments, a transcutaneous electrical nerve stimulation unit with three months of supplies and a lumbar back support.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the thoracic spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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

Decision rationale: ACOEM chapter on back complaints describes that MRI is indicated when there are unequivocal objective findings of specific nerve compromise in a person with symptoms who do not respond to treatment and for whom surgery would be a reasonable intervention. There are no unequivocal physical examination findings to suggest disk herniation and there is no other testing that documents any radiculopathy. MRI thoracic spine is not medically necessary.

Physical therapy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 83, Chronic Pain Treatment Guidelines Physical medicine Page(s): 103.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section 2 Page(s): 98-99.

Decision rationale: The CA MTUS recommends physical therapy for management of chronic pain with a clear preference for active therapy over passive therapy. Physical therapy includes supervision by therapist then the patient is expected to continue active therapies at home in order to maintain improvement levels. Guidelines direct fading treatment frequency from 3 times a week to one or less with guidelines ranging depending on the indication: Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks, Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2), 8-10 visits over 4 weeks, Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks. In this case, the claimant has already completed more than 10 physical therapy visits and the medical records do not contain any information that would support any additional expected benefit from additional physical therapy. The request for additional physical therapy sessions is not medically necessary.

Acupuncture: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: CA MTUS guidelines state that acupuncture is used as an option when pain medication is reduced or not tolerated, it may be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. The frequency and duration of acupuncture or acupuncture with electrical stimulation may be performed as follows: (1) Time to produce functional improvement: 3 to 6 treatments (2) Frequency: 1 to 3 times per week (3) Optimum duration: 1 to 2 months. Acupuncture treatments may be extended if functional

improvement is documented. In this case, there is no documentation of intolerance to pain medication or of other physical rehabilitation interventions. As such, the use of acupuncture is not medically necessary.

TENS unit 3 month supplies: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 12-127.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section 2 Page(s): 116.

Decision rationale: CA MTUS states that TENS units are not first line therapy but may be considered if those treatments have failed. Indications for use include : Chronic intractable pain with documentation of pain of at least three months duration, evidence that other appropriate pain modalities have been tried (including medication) and failed, a one-month trial period of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; rental would be preferred over purchase during this trial. Other ongoing pain treatment should also be documented during the trial period including medication usage. A treatment plan including the specific short- and long-term goals of treatment with the TENS unit should be submitted. In this case there is no documentation of response to use of TENS unit, no documentation of short or long-term goals of therapy. As the ongoing use of the TENS unit is not medically necessary, TENS unit supplies are not medically necessary.

Lumbar back support: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 300-301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

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

Decision rationale: ACOEM chapter on back complaints states that lumbar supports have not been shown to have any lasting benefits beyond the acute phase of symptom relief. The injury in this case is two years old. Therefore, the lumbar support is not medically necessary.