

Case Number:	CM13-0001270		
Date Assigned:	11/27/2013	Date of Injury:	03/09/2012
Decision Date:	01/24/2014	UR Denial Date:	07/01/2013
Priority:	Standard	Application Received:	07/11/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation and is licensed to practice in Illinois. 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 physician 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 a 55-year-old female who reported an injury on 03/09/2010 due to cumulative trauma while performing normal job duties. The patient developed chronic low back pain and left upper leg pain. The patient was treated conservatively with physical therapy, a home exercise program, a TENS unit, and medications. The patient underwent an x-ray of the lumbar spine that revealed mild anterolisthesis and motion at the L2-3. The patient underwent an MRI that revealed facet degenerative changes of the lumbar spine at the L2-3 level with no evidence of central canal stenosis, neural foraminal narrowing, or fracture. The patient underwent left epidural steroid injections at the L4-5 and L5-S1. The patient's most recent clinical exam findings included tenderness to palpation over the facet joints at the L2-3 and L3-4 levels with increased pain with axial loading. The patient's diagnoses included lumbar disc degeneration and worsening spondylosis. The patient's treatment plan included a medial branch block at the L2-3 and L3-4 and continued medication usage.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral transforaminal epidural steroid injections L4-5 QTY:2: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection Page(s): 46.

Decision rationale: The requested bilateral transforaminal epidural steroid injection L4-5 QTY:2 is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has low back pain. Additionally, it is noted within the documentation that the patient has previously undergone epidural steroid injections at the requested level. Also, the request is for two epidural steroid injections. California Medical Treatment Utilization Schedule recommends repeat injections be based on significant functional improvement and pain relief. The clinical documentation submitted for review did not include any evidence of functional benefit or pain relief from the prior injections. Additionally, the most recent clinical documentation did not include any evidence of radicular pain that would respond to an epidural steroid injection. As such, the requested bilateral transforaminal epidural steroid injection L4-5 QTY:2 is not medically necessary or appropriate.

Bilateral transforaminal epidural steroid injections L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46.

Decision rationale: The requested bilateral transforaminal epidural steroid injection L5-S1 is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient has low back pain. Additionally, it is noted within the documentation that the patient has previously undergone epidural steroid injections at the requested level. Also, the request is for two epidural steroid injections. California Medical Treatment Utilization Schedule recommends repeat injections be based on significant functional improvement and pain relief. The clinical documentation submitted for review did not include any evidence of functional benefit or pain relief from the prior injections. Additionally, the most recent clinical documentation did not include any evidence of radicular pain that would respond to an epidural steroid injection. As such, the requested bilateral transforaminal epidural steroid injection L5-S1 is not medically necessary or appropriate.

H-Wave purchase: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-121.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H-Wave Page(s): 117.

Decision rationale: The requested H-Wave purchase is not medically necessary or appropriate. The clinical documentation submitted for review does provide evidence that the patient is currently participating in a home exercise program and has chronic pain that has been

nonresponsive to more conservative treatments such as physical therapy and a TENS unit. California Medical Treatment Utilization Schedule recommends the purchase of an H-wave unit be based on a 30 day trial. The clinical documentation submitted for review does not provide any evidence that the patient has undergone a trial period of H-wave therapy. As such, the requested H-Wave purchase is not medically necessary or appropriate.

Iontophoresis: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back chapter: Iontrophoresis.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Iontophoresis.

Decision rationale: The request iontophoresis is not medically necessary or appropriate. The clinical documentation submitted for review does indicate that the patient has persistent low back pain that has been nonresponsive to other conservative treatments, including medications. However, Official Disability Guidelines do not recommend this type of therapy as a treatment option when treating low back pain. The clinical documentation submitted for review does not provide any exceptional factors to extend treatment beyond guideline recommendations. As such, the requested iontophoresis is not medically necessary or appropriate.