

Case Number:	CM13-0024588		
Date Assigned:	11/20/2013	Date of Injury:	11/09/2010
Decision Date:	03/11/2014	UR Denial Date:	08/20/2013
Priority:	Standard	Application Received:	09/13/2013

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 Physical Medicine and Rehabilitation and is licensed to practice in New York and Texas 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 49-year-old injured worker who reported an injury on 11/09/2010. The patient is currently diagnosed with lumbar degenerative disc disease, discogenic low back pain, right L5 radiculitis/radiculopathy, right S1 radiculitis/radiculopathy, and chronic pain syndrome and knee pain. The patient was seen by [REDACTED] on 07/05/2013. The patient reported ongoing lower back pain with radiation to the bilateral lower extremities. Physical examination revealed tenderness to palpation, positive straight leg raise, decreased sensation in the anterior and medial thigh, weakness with hip flexion and reduced sensation to light touch, pinprick and vibration along the lateral right lower extremity. Treatment recommendations included an epidural steroid injection, a lumbar brace and H-wave stimulation.

IMR ISSUES, DECISIONS AND RATIONALES

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

One right L5 and S1 transforaminal epidural steroid injection under fluoroscopic guidance and conscious sedation: Upheld

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

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

Decision rationale: The California MTUS Guidelines state that epidural steroid injections are recommended as an option for the treatment of radicular pain with use in conjunction with other rehab efforts. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. As per the documentation submitted, the patient has undergone an electrodiagnostic study, which did indicate evidence of a right L5 and S1 chronic radiculopathy. While it is noted that the patient has been previously treated with home exercise, physical therapy and a TENS unit trial; there are no evidence-based guidelines to support sedation during the procedure. The request for one right L5 and S1 transforaminal epidural steroid injection under fluoroscopic guidance and conscious sedation is not medically necessary and appropriate.

One lumbar brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Lumbar Supports

Decision rationale: The California MTUS/ACOEM Practice Guidelines state that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptom relief. As per the documentation submitted, the patient indicated that they had a lumbar support brace in the past. The medical necessity for an additional lumbar support brace has not been established. Additionally, there was no evidence of significant instability upon physical examination. The request for a lumbar brace is not medically necessary and appropriate.

One H-wave trial: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 117-121.

Decision rationale: The California MTUS Guidelines state that H-wave stimulation is not recommended as an isolated intervention, but a 1 month home-based trial may be considered as a noninvasive conservative option for diabetic neuropathic pain or chronic soft tissue inflammation. H-wave stimulation should be used as an adjunct to a program of evidence-based functional restoration. As per the documentation submitted, the patient has previously undergone conservative care, including physical therapy, home exercise and the clinical use of a TENS unit. However, documentation of previous TENS therapy, including evidence of how often the unit was used as well as outcomes in terms of pain relief and function, were not provided for review. There was also no evidence of this patient's active participation in a functional restoration program to be used in conjunction with the H-wave stimulation. The request for a H-wave trial is not medically necessary and appropriate.

