

Case Number:	CM13-0027769		
Date Assigned:	11/22/2013	Date of Injury:	03/25/2013
Decision Date:	02/10/2014	UR Denial Date:	08/28/2013
Priority:	Standard	Application Received:	09/23/2013

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 & Rehabilitation and Pain Medicine and is licensed to practice in Oklahoma 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 30-year-old male who reported a lifting injury on 03/25/2013. His diagnoses are lumbar spine musculoligamentous sprain with grade 1 anterolisthesis at L5-S1 and status post right inguinal hernia repair performed on 08/06/2013. His symptoms include low back pain and right inguinal pain. Objective findings include tenderness over the lumbar paraspinal musculature on the right side with spasm, positive straight leg raise testing, limited lumbar range of motion, and mild to moderate swelling of the right groin. An x ray of the lumbar spine was obtained and revealed spina bifida occulta at L5, a home H-Wave unit was requested to help control lumbar paraspinal

IMR ISSUES, DECISIONS AND RATIONALES

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

An H-wave unit: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines H-wave stimulation Page(s): 117-118.

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 of H Wave stimulation

may be considered as a non-invasive conservative option if used as an adjunct to a program of evidence-based functional restoration, and only following failure of initially recommended conservative care, including recommended physical therapy and medications, plus transcutaneous electrical nerve stimulation. The records indicate that the patient is participating in a home exercise program with stretching. However, there is no documentation of failure of physical therapy with a TENS unit. Additionally, the medical records provided for review did not include a plan for the patient to participate in a program of evidence-based functional restoration. Furthermore, the request for an H-Wave unit did not specify whether the request was for a 1-month trial of the unit as recommended by the Guidelines. The Guidelines also specify that during the 1-month trial, rental would be preferred over purchase. As the patient was not noted to have failed a formal physical therapy program plus a TENS unit, is not participating in a program of evidence-based functional restoration, and the request is not specified for a 1 month rental of an H-Wave unit, the request is not supported by Guidelines. Therefore, the request for an H-wave unit is non-certified.

Norco 10/325 mg #120: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, Ongoing Management Page(s): 78.

Decision rationale: The California MTUS Guidelines state there should be ongoing review and documentation of pain relief, functional status, appropriate medication use and side effects as well as aberrant drug-taking behaviors. It was noted that the patient complained of low back and right groin pain. There were positive objective findings of tenderness, as well as limited range of motion of the lumbar spine, and swelling to the right groin area. However, the detailed documentation required by Guidelines to include pain relief and objective functional improvement as a result of the requested medication were not provided to support continuation. Therefore, the requested Norco 10/325mg #120 is non-certified.

An x-ray 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): 303-305.

Decision rationale: According to CA MTUS/ACOEM Guidelines, lumbar spine x-rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least 6 weeks. However, it may be appropriate when the physician believes it would aid in patient management. It was noted that the physician believes that in order to prevent further debilitation and progression of pain, curvature, and posture problems of the spine that may only worsen the condition, proper assessment and

monitoring should therefore be performed and this includes appropriate diagnostic tests so that ineffective treatments and any missed or overlooked diagnoses can be prevented. However, the clinical information submitted indicated the patient underwent x-rays of the lumbar spine on 08/20/2013 which revealed spinal bifida occulta at L5. The physician did not provide a rationale to support repeating lumbar spine x-rays when the ones performed in 08/2013 were diagnostic in nature. Therefore, the request for a second x-ray of the lumbar spine is non-certified.