

Case Number:	CM13-0030668		
Date Assigned:	11/27/2013	Date of Injury:	05/03/1999
Decision Date:	02/07/2014	UR Denial Date:	09/11/2013
Priority:	Standard	Application Received:	09/30/2013

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 Pain Management, has a subspecialty in Disability Evaluation and is licensed to practice in California. 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:

According to the clinical documentation, the patient is a 43-year-old individual who sustained a cumulative injury to Knees and back on 05/03/99 "when a patient fell on her". The Initial Pain Management Evaluation dated 08/26/13 by [REDACTED] documented that the patient complained of low back pain radiating to the left lower extremity the patient also noted numbness and tingling in the bilateral lower extremities to the level of the toes left greater than right. The pain was described as sharp in severity. The current pain scale was 9-10 out of 10, aggravated by standing, walking, sitting, bending, twisting, turning, and rotation. The patient reported severe insomnia secondary to pain. Prior treatments included a lumbar spine surgery in 2000-2001 which was helpful (type of surgical intervention unspecified); medications which provided temporary benefit; physical therapy, acupuncture and chiropractic which also provided temporary benefit; and lumbar epidural steroid injection (date of procedure unspecified) which provided temporary benefit. Past medical history was remarkable for hypertension. The patient also had a history of falling from stairs and had low back pain in 2009. The patient was reportedly taking Flexeril 100 mg t.i.d. p.r.n., Neurontin 300 mg t.i.d. po q.8 hours, Norco 10/325 q. 6 hours, Xanax p.r.n., hypertension medications (name, dosage and schedule of use unspecified), and lisinopril/ASA (acetylsalicylic acid) 81 mg. The patient reported no known drug allergies. On physical examination, the patient stood 5 feet 8 inches and weighed 280 pounds. The patient was observed to be in moderate in distress. The patient's gait was slow. Inspection of the lumbar spine revealed a well healed surgical scar. Spinal vertebral tenderness was noted in the lumbar spine at the L3-S1 levels. Spinal vertebral tenderness was noted in the lumbar spine at the L3-S1 levels. The range of motion of the lumbar spine was limited secondary to pain. Pain was significantl

IMR ISSUES, DECISIONS AND RATIONALES

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

Left L4-S1 transforaminal epidural: 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: CA-MTUS (Effective July 18, 2009) page 46 of 127, stipulates that "the purpose of Epidural Steroid Injections (ESI) is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit". Occupational Medicine Treatment Guidelines (page 300) stated "Invasive techniques (e.g., local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit. Although epidural steroid injections may afford short-term improvement in leg pain and sensory deficits in patients with nerve root compression due to a herniated nucleus pulposus, this treatment offers no significant long term functional benefit, nor does it reduce the need for surgery. Criteria for the use of Epidural steroid injections: Note: The purpose of ESI is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). 3) Injections should be performed using fluoroscopy (live x-ray) for guidance. 4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections. 5) No more than two nerve root levels should be injected using transforaminal blocks. 6) No more than one interlaminar level should be injected at one session. 7) In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007) 8) Current research does not support a "series-of-three" injection in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections. MRI of the lumbosacral spine dated 03/13/12 documented the following impression: "L4-L5 level: There is a 2 mm left posterolateral disc protrusion resulting in mild left neural foramina! narrowing. L5-S1 level: There is a 2 mm left posterolateral disc protrusion resulting in mild left neural foramina! narrowing. There is mild disc desiccation, adjacent endplate changes and mild right facet arthropathy." There is no significant pathology on MRI and no Electro-diagnostic studies performed to collaborate with clinical findings. There was not documentation of the benefit of previous epidural injec

Interferential unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

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

Decision rationale: CA-MTUS (Effective July 18, 2009) page 117 to 118 of 127, section on H-Wave Stimulations states: Not recommended as an isolated intervention, but a one-month home-based trial of H-Wave stimulation may be considered as a noninvasive conservative option for diabetic neuropathic pain (Julka, 1998) (Kumar, 1997) (Kumar, 1998), or chronic soft tissue inflammation 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 (i.e., exercise) and medications, plus transcutaneous electrical nerve stimulation (TENS). In a recent retrospective study suggesting effectiveness of the H-wave device, the patient selection criteria included a physician documented diagnosis of chronic soft-tissue injury or neuropathic pain in an upper or lower extremity or the spine that was unresponsive to conventional therapy, including physical therapy, medications, and TENS. (Blum, 2006) (Blum2, 2006) There is no evidence that H-Wave is more effective as an initial treatment when compared to TENS for analgesic effects. A randomized controlled trial comparing analgesic effects of H-wave therapy and TENS on pain threshold found that there were no differences between the different modalities or HWT frequencies. (McDowell2, 1999) [Note: This may be a different device than the H-Wave approved for use in the US.] Regarding tissue repair, another study suggests that low-frequency HWT may produce direct localized effects on cutaneous blood flow, a finding relevant for clinicians working in the field of tissue repair. (McDowell, 1999) The one-month HWT trial may be appropriate to permit the physician and provider licensed to provide physical therapy to study the effects and benefits, and it should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) as to 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. Trial periods of more than one month should be justified by documentation submitted for review. While H-Wave and other similar type devices can be useful for pain management, they are most successfully used as a tool in combination with functional improvement. H-wave stimulation is a form of electrical stimulation that differs from other forms of electrical stimulation, such as transcutaneous electrical nerve stimulation (TENS), in terms of its waveform. There is no current program of evidence-based functional restoration as recommended by the guidelines documented by the rendering provider or any documentation of failure of initially recommended conservative care including recommended physical therapy and medications as well as transcutaneous electrical nerve stimulation (TENS); hence the request for H-Wave Unit is not medically necessary.

Cold therapy unit 60 day rental: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 308-310.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder Chapter page 11, and Low back Chapter

Decision rationale: CA-MTUS (Effective July 18 2009) is mute on this topic. ODG Shoulder Chapter page 11, Continuous Flow Cryotherapy (e.g. Q-Tech Recovery System) is recommended as an option after surgery, but not for non-surgical treatment. Post-operative use generally may be up to 7 days, including home use. In the post-operative setting, continuous cryo-therapy units have been proven to decrease pain, inflammation, swelling, and narcotic usage, however, the effect on more frequently treated acute injuries (e.g. muscle strains and contusions) has not been fully evaluated. Continuous-flow cryo-therapy units provide requested temperature through use of power to circulate ice water in the cooling packs. Recommended as an option for acute pain. At-home local applications of cold packs in first few days of acute complaint; thereafter, applications of heat packs or cold packs. (Bigos, 1999) (Airaksinen, 2003) (Bleakley, 2004) (Hubbard, 2004) Continuous low-level heat wrap therapy is superior to both acetaminophen and ibuprofen for treating low back pain. (Nadler 2003) The evidence for the application of cold treatment to low-back pain is more limited than heat therapy, with only three poor quality studies located that support its use, but studies confirm that it may be a low risk low cost option. (French-Cochrane, 2006) There is minimal evidence supporting the use of cold therapy, but heat therapy has been found to be helpful for pain reduction and return to normal function. (Kinkade, 2007) Therefore the request for cold therapy unit 60 day rental is not medically necessary since it is recommended as an option after surgery.

Protonix DR 20 mg, #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG Low Back Cold/heat packs

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 68.

Decision rationale: Protonix is recommended with precautions in patients taking NSAID, because of potential development of gastro-intestinal bleeding. Norco does not have NSAID properties, and therefore the addition of Protonix is not related to Norco therapy. Norco is used to relieve moderate to severe pain. It is a combination of hydrocodone, a narcotic pain reliever, and acetaminophen, an analgesic pain reliever. Common side effects include nausea, vomiting, constipation, lightheadedness, dizziness, or drowsiness. According to Chronic Pain Medical Treatment Guidelines page 68 (MTUS -Effective July 18, 2009) clinicians should weight the indications for NSAIDs against both GI and cardiovascular risk factors. Determine if the patient is at risk for gastrointestinal events: (1) age > 65 years; (2) history of peptic ulcer, GI bleeding or perforation; (3) concurrent use of ASA, corticosteroids, and/or an anticoagulant; or (4) high dose/multiple NSAID (e.g., NSAID + low-dose ASA). The patient does not fall into any of these categories; hence the guideline does not apply to this patient. In addition, the medical record reviewed indicated that the gastro-intestinal examination was normal. Based on the foregoing, the request for Protonix 20mg #60 is not medically necessary