

Case Number:	CM14-0012827		
Date Assigned:	02/24/2014	Date of Injury:	03/12/2010
Decision Date:	08/01/2014	UR Denial Date:	01/22/2014
Priority:	Standard	Application Received:	01/31/2014

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. The expert reviewer is Board Certified in Occupational Medicine 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 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/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 43-year-old male who has filed a claim for lumbar postlaminectomy syndrome associated with an industrial injury date of March 12, 2010. Review of progress notes indicates increasing low back pain radiating to posterior thighs with spasms, more on the left. There is aching of both feet. Findings include antalgic gait, tenderness over the lumbosacral region with decreased range of motion due to pain, positive straight leg raise test bilaterally, and pain upon internal and external rotation of bilateral hips. Lumbar MRI dated September 16, 2013 showed surgical changes on the left L5-S1 with desiccation, narrowing, disc bulge, and left inferior neuroforaminal narrowing without displacement of the L5 ganglion or S1 nerve roots. Treatment to date has included Tylenol, steroids, muscle relaxants, sedatives, opioids, Lyrica, bone growth stimulator, lumbar spinal surgeries in April 2011 and November 07, 2013. Utilization review from January 22, 2014 denied the requests for lumbar caudal block as there was no clear documentation of radiculopathy; series of three trigger point injections as there was no documentation of circumscribed trigger points; updated front wheel walker as there was no indication of the need for another walker; and additional one month rental for hospital bed as there was no indication for the medical necessity of this request.

IMR ISSUES, DECISIONS AND RATIONALES

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

LUMBAR CAUDAL BLOCK: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines : CHRONIC PAIN MEDICAL TREATMENT GUIDELINES.

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

Decision rationale: As stated on page 46 of CA MTUS Chronic Pain Medical Treatment Guidelines, there is no support for epidural injections in the absence of objective radiculopathy. Criteria for the use of epidural steroid injections include an imaging study documenting correlating concordant nerve root pathology and conservative treatment. In this case, the patient presents with worsening of low back pain post-operatively. However, there is no clear documentation of radiculopathy. The specific level/s for lumbar block is also not indicated. Therefore, the request for lumbar caudal block was not medically necessary.

SERIES OF THREE TRIGGER POINT INJECTIONS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines : CHRONIC PAIN MEDICAL TREATMENT GUIDELINES.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TRIGGER POINT INJECTIONS Page(s): 122.

Decision rationale: CA MTUS Chronic Pain Medical Treatment Guidelines criteria for trigger point injections include chronic low back or neck pain with myofascial pain syndrome. There should be circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain; symptoms for more than three months; failure of medical management therapies; absence of radiculopathy; and no more than 3-4 injections per session. Additionally, repeat injections are not recommended unless greater than 50% pain relief has been obtained for six weeks following previous injections, including functional improvement. In this case, there is no documentation of presence of trigger points to support this request. Therefore, the request for series of three trigger point injections was not medically necessary.

UPDATED FRONT WHEELED WALKER: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines : CHRONIC PAIN MEDICAL TREATMENT GUIDELINES/ACOEM, ,.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee and Leg chapter, Walking aids (canes, crutches, braces, orthoses, & walkers).

Decision rationale: The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, ODG was used instead. According to ODG, frames or wheeled walkers are preferable for patients with bilateral disease. Progress notes indicate that the patient has significantly decreased mobility post-operatively and walks with an antalgic gait. However,

previous utilization review dated January 22, 2014 notes that the patient already has a walker. Also, the patient does not present with bilateral lower extremity disease, for which this is recommended. The indication for a new walker at this time is not clear. Therefore, the request for updated front wheeled walker was not medically necessary.

ADDITIONAL ONE MONTH RENTAL FOR HOSPITAL BED: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management.

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, Mattress selection Other Medical Treatment Guideline or Medical Evidence: Aetna Clinical Policy Bulletin: Hospital Beds and Accessories.

Decision rationale: The CA MTUS does not address this topic. Per the Strength of Evidence hierarchy established by the California Department of Industrial Relations, Division of Workers' Compensation, ODG was used instead. According to ODG, it is not recommended to use firmness as a sole criterion for mattress selection. In addition, Aetna considers hospital beds and accessories medically necessary durable medical equipment for patients who meet any of the following: if the patient's condition requires positioning of the body in ways not feasible in an ordinary bed; if the patient's condition requires special attachments; and if the patient requires the head of the bed elevated > 30 degrees most of the time due to congestive heart failure, chronic pulmonary disease, or problems with aspiration. Variable height feature is necessary for patients with any of the following: severe arthritis and injuries to the lower extremities, severe cardiac conditions precluding the patient from straining to get up and down the bed; spinal cord injuries, limb amputees, and stroke; and other severely debilitating conditions. In this case, the patient presents with worsening of the pain condition after a lumbar fusion surgery in November 2013. The requesting physician notes that additional use of the hospital bed is necessary due to decreased mobility. However, there is no mention of any of the conditions outlined above. Therefore, the request for additional one month rental for hospital bed was not medically necessary.