

Case Number:	CM14-0127112		
Date Assigned:	08/13/2014	Date of Injury:	05/20/1983
Decision Date:	09/11/2014	UR Denial Date:	08/01/2014
Priority:	Standard	Application Received:	08/11/2014

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 Internal 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 an injured worker with disc disease and lumbar spine radiculopathy. The date of injury was 05-20-1983. The patient injured her back while unloading baggage. A progress report dated July 3, 2014 documented subjective complaints of low back pain that is now moderate to severe. The pain is 6 to 7/10. She is trying to do physical therapy. She is not taking narcotic-based medications, just anti-inflammatory medication, but the pain has persevered. In July 2013, she had an electromyogram and nerve conduction studies (EMG/NCV) performed that showed an L5 radiculopathy on the right side. On physical examination blood pressure is 120/70, pulse is 70, respirations are 14, and temperature is 98.7. Lungs are clear to auscultation. The heart has a regular rate and rhythm. Strength is 5/5 bilaterally in the lower extremities. Sensation is decreased in the right L5 dermatome. She has a hypoactive right patellar tendon and right ankle reflex. She has positive straight leg raising at 30 degrees in the right lower extremity. She has decreased lumbar spine range of motion with lumbar spine flexion and extension. With flexion she has pain shooting down her right leg. Diagnoses were lumbar disc disease and lumbar spine radiculopathy. The treatment plan included right L5 transforaminal steroid injection. Request for authorization (RFA) dated 07-24-2014 requested right L5 transforaminal steroid injection. Utilization review dated 08-01-2014 recommended approval of right L5 transforaminal steroid injection and follow up pain medicine evaluation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar Epidural Steroid Injection (level/site unspecified) QTY: 1: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESI's) Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medical treatment utilization schedule (MTUS) Epidural steroid injections (ESIs) Page 46 Page(s): 46.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines present criteria for the use of Epidural Steroid Injections (ESI). Chronic Pain Medical Treatment Guidelines (Page 46) states that Epidural Steroid Injections (ESIs) are recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). Criteria for the use of Epidural Steroid Injections requires that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Utilization review dated 08-01-2014 recommended approval of right L5 transforaminal steroid injection. Progress report dated July 3, 2014 documented the diagnoses of lumbar disc disease and lumbar spine radiculopathy. Electromyogram and nerve conduction studies (EMG/NCV) performed in July 2013 showed L5 radiculopathy on the right side. Physical examination findings included sensation decreased in the right L5 dermatome, hypoactive right patellar tendon and right ankle reflex, positive straight leg raising at 30 degrees in the right lower extremity, decreased lumbar spine range of motion with lumbar spine flexion and extension, pain shooting down her right leg. Utilization review dated 08-01-2014 recommended approval of right L5 transforaminal steroid injection. Therefore, the request for Lumbar Epidural Steroid Injection (level/site unspecified) QTY: 1 is medically necessary.

Shockwave Therapy, Lumbar Spine QTY: 12: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines) Low Back, Shock Wave Therapy.

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 - Lumbar & Thoracic (Acute & Chronic) Shock Wave Therapy Work Loss Data Institute. Bibliographic Source: Work Loss Data Institute. Low back -- lumbar & thoracic (acute & chronic). Encinitas (CA): Work Loss Data Institute; 2013 Dec 4. Guideline.Gov.

Decision rationale: ACOEM Chapter 12 - Low Back Complaints states that physical modalities such as massage, diathermy, cutaneous laser treatment, ultrasound, transcutaneous electrical neurostimulation (TENS) units, percutaneous electrical nerve stimulation (PENS) units, and biofeedback have no proven efficacy in treating acute low back symptoms. Insufficient scientific testing exists to determine the effectiveness of these therapies. Medical treatment utilization schedule (MTUS) does not specifically address extracorporeal shockwave therapy (ESWT) for low back conditions. Official Disability Guidelines (ODG) state that shock wave therapy is not recommended. The available evidence does not support the effectiveness of ultrasound or shock wave for treating low back pain. In the absence of such evidence, the clinical use of these forms

of treatment is not justified and should be discouraged. Work Loss Data Institute guidelines for the low back state that shock wave therapy is not recommended. Progress report dated July 3, 2014 documented the diagnoses of lumbar disc disease and lumbar spine radiculopathy. ACOEM, ODG, and Work Loss Data Institute guidelines do not support the utilization of shock wave therapy. Therefore, the request for Shockwave Therapy, Lumbar Spine QTY: 12, is not medically necessary.

Physical Therapy, Lumbar Spine QTY: 12: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Medical treatment utilization schedule (MTUS) Physical Therapy/Physical Medicine Postsurgical Treatment Guidelines Page(s): 98-99, 25-26. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic) Physical Therapy.

Decision rationale: Medical treatment utilization schedule (MTUS) Chronic Pain Medical Treatment Guidelines provide Physical Therapy/Physical Medicine guidelines. For myalgia and myositis, 9-10 visits are recommended. For neuralgia, neuritis, and radiculitis, 8-10 visits are recommended. Official Disability Guidelines (ODG) recommends 1 to 2 post-injection physical therapy treatments. The progress report dated July 3, 2014 documented the diagnoses of lumbar disc disease and lumbar spine radiculopathy. Utilization review dated 08-01-2014 recommended approval of right L5 transforaminal steroid injection. Twelve physical therapy treatments were requested, which exceeds the ODG guideline recommendation of 2 post-injection physical therapy treatments following epidural steroid injections (ESI). ODG and MTUS guidelines do not support the medical necessity of 12 post-ESI Physical Therapy visits. Therefore, the request for Physical Therapy, Lumbar Spine QTY: 12 is not medically necessary.

Acupuncture, Lumbar Spine QTY: 12: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Acupuncture Treatment Guidelines.

Decision rationale: Medical treatment utilization schedule (MTUS) addresses acupuncture. American College of Occupational and Environmental Medicine (ACOEM) Chapter 12- Low Back Complaints (Page 300) states that acupuncture has not been found effective in the management of back pain, based on several high-quality studies. Acupuncture Medical Treatment Guidelines recommend that the time to produce functional improvement is 3 to 6 treatments. The progress report dated July 3, 2014 documented the diagnoses of lumbar disc disease and lumbar spine radiculopathy. Twelve acupuncture treatments were requested, which exceeds the MTUS guideline recommendation of 6 treatments to produce functional

improvement. Therefore, the request for Acupuncture, Lumbar Spine QTY: 12 is not medically necessary.

H-Wave Unit QTY: 1: Upheld

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

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

Decision rationale: Medical treatment utilization schedule (MTUS) Chronic Pain Medical Treatment Guidelines addresses H-wave stimulation (HWT). H-wave stimulation may be considered for chronic soft tissue inflammation, if used as an adjunct to an evidence-based functional restoration program (FRP), and only following failure of transcutaneous electrical nerve stimulation (TENS). American College of Occupational and Environmental Medicine (ACOEM) Chapter 12- Low Back Complaints states that physical modalities such as massage, diathermy, cutaneous laser treatment, ultrasound, transcutaneous electrical neurostimulation (TENS) units, percutaneous electrical nerve stimulation (PENS) units, and biofeedback have no proven efficacy in treating acute low back symptoms. Insufficient scientific testing exists to determine the effectiveness of these therapies. Table 12-8 Summary of Recommendations for Evaluating and Managing Low Back Complaints states that TENS is not recommended. ACOEM states that H-wave stimulation is not recommended for low back disorders. The progress report dated July 3, 2014 documented the diagnoses of lumbar disc disease and lumbar spine radiculopathy. Medical records do not document enrollment in a functional restoration program (FRP), which is a requirement per MTUS guidelines. Medical records do not document failure of TENS, which is a requirement per MTUS guidelines. ACOEM guidelines do not support the use of H-wave stimulation for low back disorders. Therefore, the request for H-Wave Unit QTY: 1 is not medically necessary.

Exercise Ball QTY: 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99.

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 - Lumbar & Thoracic (Acute & Chronic) Exercise Official Disability Guidelines (ODG) Knee & Leg (Acute & Chronic) Durable medical equipment (DME) Exercise equipment.

Decision rationale: Medical treatment utilization schedule (MTUS) does not address exercise equipment. Official Disability Guidelines (ODG) state that exercise equipment is considered not primarily medical in nature. Exercise equipment may not be covered. The request was for an exercise ball. ODG guidelines do not support the medical necessity of an exercise ball and other exercise equipment. Therefore, the request for an Exercise Ball QTY: 1 is not medically necessary.

Hot/Cold Therapy Unit QTY: 1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG (Official Disability Guidelines)Low back.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, 308-310.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses physical methods and thermal modalities. American College of Occupational and Environmental Medicine (ACOEM), Chapter 12- Low Back Complaints states that physical modalities have no proven efficacy in treating acute low back symptoms. Insufficient scientific testing exists to determine the effectiveness of these therapies, but they may have some value in the short term if used in conjunction with a program of functional restoration. At-home local applications of heat or cold are as effective as those performed by therapists. Table 12-8 Summary of Recommendations for Evaluating and Managing Low Back Complaints states that at-home applications of local heat or cold to low back are optional, are not endorsed as recommended physical treatment methods. ACOEM addresses thermal modalities such as heat and cryotherapies. ACOEM recommends self-application of heat therapy and low-tech cryotherapy for low back disorders. Application of heat (such as infrared, moist heat, whirlpool) by a health care provider is not recommended. Home use of a high-tech cryotherapy device is not recommended. The progress report dated July 3, 2014 documented the diagnoses of lumbar disc disease and lumbar spine radiculopathy. MTUS and ACOEM guideline do not endorse heat and cold therapy devices for low back conditions. Therefore, the request for Hot/Cold Therapy Unit QTY: 1 is not medically necessary.

Follow-up Pain Medicine Evaluation QTY: 1: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Occupational Medicine Practice Guideline page 89.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 75. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM)Chapter 7 Independent Medical Examiner.

Decision rationale: Medical treatment utilization schedule (MTUS) addresses occupational physicians and other health professionals. American College of Occupational and Environmental Medicine (ACOEM) Chapter 5 -Cornerstones of Disability Prevention and Management (Page 75) states that occupational physicians and other health professionals who treat work-related injuries and illness can make an important contribution to the appropriate management of work-related symptoms, illnesses, or injuries by managing disability and time lost from work as well as medical care. ACOEM Chapter 7- Independent Medical Examiner (Page 127) states that the health practitioner may refer to other specialists when the plan or course of care may benefit

from additional expertise. A referral may be for consultation to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss, or fitness for return to work. A consultant may act in an advisory capacity, or may take full responsibility for investigation and treatment of a patient. Utilization review dated 08-01-2014 recommended approval of right L5 transforaminal steroid injection and follow up pain medicine evaluation. It is reasonable to have a follow up pain medicine evaluation after epidural steroid injection. Therefore, the request for Follow-up Pain Medicine Evaluation QTY: 1 is medically necessary.