

Case Number:	CM14-0024207		
Date Assigned:	06/13/2014	Date of Injury:	02/28/2013
Decision Date:	08/04/2014	UR Denial Date:	02/12/2014
Priority:	Standard	Application Received:	02/26/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain 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:

This is a 52-year-old male who sustained a remote industrial injury on 02/28/13 diagnosed with disc degeneration of the lumbar spine and facet arthropathy. Mechanism of injury is not specified. The request for Bilateral Lumbar Epidural Injections at L4-5 was non-certified at utilization review due to the lack of corroborating diagnostic studies to support radiculopathy. The request for Physical Therapy 2 times per week for 4 weeks for low back was also non-certified at utilization review due to the lack of specific treatment goals and the note highlighted in the progress report that physical therapy has not helped the patient. The request for H-Wave unit for the lower back was also non-certified due to the lack of documentation specifying patient participation in a home exercise program and the failure of a transcutaneous electrical nerve stimulation (TENS) unit trial. The most recent progress note provided is 01/14/14. Patient complains primarily of weakness of the right lower extremity with spasm. Physical exam findings reveal paraspinal spasm; a flexed lumbar spine when walking; positive sciatic notch pain; decreased sensation in the left lower extremity in the S1 nerve root distribution; and decreased range of motion. Current medications are not listed. It is noted that an H-wave unit has helped in the past, physical therapy has not helped much, and an electromyography/ nerve conduction study (EMG/NCS) of the bilateral lower extremities was requested to rule out any radiculopathy. This request was approved in the previous Utilization Review but the findings are not included in the documents. Provided documents include previous progress reports and several handwritten physical therapy notes that highlight a TENS unit was utilized. The patient's previous treatments include acupuncture, H-wave unit, and 18 sessions of physical therapy. Imaging studies provided include a magnetic resonance imaging (MRI) of the lumbar spine, performed on 10/15/13. The impression of this MRI reveals mild-moderate 3 mm L4-5 diffuse disc bulging with mild posterior endplate degenerative changes and mild encroachment upon the

neural foramina; moderate L5-S1 degenerative disc disease with moderate 5 mm diffuse disc bulging, mild posterior endplate degenerative changes, mild degenerative changes of the facet joints, and mild encroachment upon the neural foramina; and oval 8 x 10 mm benign bone cyst in the L4 vertebral body near its inferior endplate. There is no evidence of disc protrusion, nerve root impingement, or spinal canal stenosis. An MRI of the cervical spine, performed on 10/15/13, reveals moderate-severe C6-7 degenerative disc disease with mild 2 mm diffuse disc bulging, mild-moderate anterior and posterior endplate degenerative changes, and moderate encroachment upon the neural foramina.

IMR ISSUES, DECISIONS AND RATIONALES

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

LEFT LUMBAR EPIDURAL INJECTION AT L4-5: Upheld

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

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

Decision rationale: According to CA MTUS guidelines on epidural steroid injections, Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. In this case, there are no objective findings involving the L4-5 level in the most recent physical examination indicative of radiculopathy as the neurological exam and lower extremities exam are unremarkable. Further, radiculopathy is not thoroughly documented in the MRI of the lumbar spine, and an EMG/NCS of the lower extremities has been approved but the results of this report are not provided for review. Without these objective findings indicating radiculopathy, medical necessity cannot be supported for the left lumbar epidural injection at L4-5.

RIGHT LUMBAR EPIDURAL INJECTION AT L4-5: Upheld

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

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

Decision rationale: According to CA MTUS guidelines on epidural steroid injections, Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. In this case, there are no objective findings involving the L4-5 level in the most recent physical examination indicative of radiculopathy as the neurological exam and lower extremities exam are unremarkable. Further, radiculopathy is not thoroughly documented in the MRI of the lumbar spine, and an EMG/NCS of the lower extremities has been approved but the results of this report are not provided for review. Without

these objective findings indicating radiculopathy, medical necessity cannot be supported therefore the right lumbar epidural injection at L4-5 is not medically necessary.

PHYSICAL THERAPY 2 X 4 WEEKS FOR LOW BACK: Upheld

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

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

Decision rationale: According to CA MTUS guidelines, Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels. Provided documentation, including the previous utilization review, notes that the patient has participated in at least 18 sessions of physical therapy. However, the treating physician does not document limitations that would necessitate more physical therapy sessions over the patient continuing therapy in a safe home exercise program. Further, additional sessions of physical therapy are recommended with documentation of specific treatment goals, which is not provided. Thus, medical necessity is not supported therefore, the request for physical therapy 2 times per week for 4 weeks for low back is not medically necessary.

H-WAVE UNIT FOR THE LOWER BACK: 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 (HWT) Page(s): 117-118.

Decision rationale: The medical necessity of H-wave unit is compared to the California MTUS criteria for utilization of H-wave unit, which notes H-wave is not recommended as an isolated intervention. A trial of H-wave unit is only recommended as noninvasive conservative option for the treatment of diabetic peripheral neuropathy pain or chronic soft tissue inflammation, which is not documented in the current clinical setting. Also, provided documentation does not describe the failure of a TENS unit as guidelines recommend prior to trial of H-wave, and physical therapy reports note that a TENS unit was utilized but the effects of this treatment are not legibly documented. Further, the current request does not specify whether the H-wave unit is for a rental or purchase and the duration of use is not specified. Therefore, medical necessity is not established and the request for H-Wave unit for the lower back is not medically necessary.