

Case Number:	CM14-0031303		
Date Assigned:	04/09/2014	Date of Injury:	03/19/2012
Decision Date:	05/28/2014	UR Denial Date:	01/02/2014
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 Physical Medicine and Rehabilitation, and is licensed to practice in Illinois. 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 injured worker is a 28-year-old female who reported an injury on 03/19/2012. The mechanism of injury was cumulative trauma. The documentation of 02/20/2013 revealed that the injured worker had previously been treated with chiropractic care and physical therapy. It was indicated that the last chiropractic treatment was in 10/2012 and that the treatment was temporarily effective in reducing pain and spasms. The injured worker had complaints of pain in the neck and the upper and lower back. The injured worker had radiation of pain into the bilateral upper extremities and pain radiating down both legs. The injured worker complained of bilateral shoulder, wrist and hand pain and trouble sleeping. The injured worker indicated that she had pins and needles in her arms and hands. The physical examination revealed that the injured worker had spasms of the cervical paraspinal muscles and tenderness over the C4-7 spinous processes. There was tenderness in both trapezius muscles and multiple trigger points throughout the trapezius and rhomboid musculature. There was a positive Spurling's test. There was decreased sensation in the C6 and C7 dermatomes on the right. The injured worker had positive Phalen's and Tinel's tests bilaterally and had equal but weak grip strength bilaterally. The physical examination of the lumbar spine and the lower extremities revealed bilateral erector spinae spasms. There was tenderness over the L4-5 and L5-S1 interspaces and both sciatic notches. The injured worker had a positive straight leg raise bilaterally at 80 degrees. The injured worker had hypoesthesia along the left L4 and S1 dermatomes and the right L5 dermatome. The lower extremity reflexes were equal and active bilaterally with no gross evidence of muscle weakness in the lower extremities. The diagnosis a cervical musculoligamentous injury, rule out disc pathology, lumbar musculoligamentous injury, rule out disc pathology, rule out cervical and lumbar radiculopathy and rule out bilateral carpal tunnel syndrome as well as cervicogenic headaches. The treatment plan included an MRI (magnetic

resonance imaging) of the cervical spine and lumbar spine, medications, 12 chiropractic sessions and a 30 day trial of H-wave treatment at home. It was indicated that the injured worker had trialed other forms of conservative treatment, including physical therapy, medications and a transcutaneous electrical nerve stimulation (TENS) unit, and had failed them. Additionally, the treatment included a [REDACTED] unit, a Lumbo-Sacral Orthosis (LSO) brace, a home traction unit and a home therapy kit as well as a follow up. The injured worker had an electromyogram (EMG)/nerve conduction velocity (NCV) of the bilateral lower extremities, which revealed that the injured worker had an abnormal study. The injured worker had a moderate L4-5 and L5-S1 poly-radikulopathy on the right and a slight to moderate L5-S1 nerve root compression on the left. The injured worker had an MRI of the lumbar spine on 03/06/2013 which revealed mild disc degeneration at L5-S1 with a 2 to 3 mm broad-based posterior disc protrusion most pronounced centrally and resulting in mild effacement of the ventral subarachnoid space. There was a 2 mm thick curvilinear annular fissure at the posterior L5-S1 disc margin. Additionally, posterior disc contour was otherwise preserved throughout the lumbar spine without evidence of neural impingement or spinal canal stenosis. The documentation of 03/21/2013 revealed that the injured worker had tenderness and spasm at the lumbar paraspinal column and tenderness in both sciatic notches. The injured worker had a positive straight leg raise in both lower extremities at 90 degrees. The injured worker had decreased sensation along the right L5 dermatome and the left L4 and S1 dermatomes. Motor strength was equal on both sides at 4-.5. The treatment plan included additional therapy for 6 times for the cervical spine, additional acupuncture treatments times 6, a neurologic consultation, a sleep study, a pain management consultation, an orthopedic consultation for carpal tunnel syndrome, an H-wave machine, [REDACTED] unit, LSO brace, lumbar traction unit and a home therapy kit, right wrist splint and gabapentin as well as transdermal analgesic ointments and a follow up visit.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE CONSULTATION WITH [REDACTED] OR [REDACTED] FOR A LUMBAR EPIDURAL BETWEEN 3/21/13 AND 12/20/13: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section Introduction Page(s): 1.

Decision rationale: The California MTUS Guidelines recommend that upon ruling out a potentially serious condition, conservative management is provided. If the complaint persists, the physician needs to reconsider the diagnosis and decide whether a specialist evaluation is necessary. The clinical documentation submitted for review indicated that the injured worker had objective findings upon physical examination, and the findings were corroborated by electromyogram (EMG) and MRI (magnetic resonance imaging) findings. Additionally, it was indicated that the injured worker had failed conservative therapy. This would support the necessity for a consultation visit. Given the above, the request for the retrospective consultation with [REDACTED] or [REDACTED] for a lumbar epidural between 03/21/2013 and 12/20/2013 is medically necessary.

RETROSPECTIVE REQUEST FOR ONE H-WAVE UNIT BETWEEN 3/21/13 AND 12/20/13: Upheld

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

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

Decision rationale: The California MTUS Guidelines do not recommend H-wave stimulation as an isolated intervention; however, it is recommended for a 1 month trial of neuropathic pain if it is used as an adjunct to a program of evidence-based restoration and only following the failure of initially recommended conservative care, including physical therapy, medications and transcutaneous electrical nerve stimulation. The clinical documentation submitted for review indicated that the injured worker met the above criteria. The physician documentation indicated the request was for a 30 day trial. However, the request as submitted failed to indicate the duration of use and whether the request was for rental or purchase. It failed to indicate that the injured worker would be utilizing it as an adjunct to other therapies. Given the above, the retrospective request for 1 H-wave unit between 03/21/2013 and 12/30/2013 is not medically necessary.

RETROSPECTIVE REQUEST FOR ONE [REDACTED] UNIT BETWEEN 3/21/13 AND 12/20/13: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Shoulder (Acute & Chronic), Continuous-flow cryotherapy.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298.

Decision rationale: The ACOEM Guidelines indicate that at-home local applications of cold in the first few days of an acute complaint are appropriate, and thereafter, applications of heat or cold. There was a lack of documentation indicating a necessity for a [REDACTED] unit versus the use of local cold packs. The request for the [REDACTED] unit failed to indicate the duration of use and whether the unit was for rental or purchase. Given the above, the retrospective request for 1 [REDACTED] unit between 03/21/2013 and 12/20/2013 is not medically necessary.

RETROSPECTIVE REQUEST FOR ONE LSO BRACE BETWEEN 3/21/13 AND 12/20/13: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298.

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

Decision rationale: The ACOEM Guidelines indicate that lumbar supports have not been shown to have any lasting benefit beyond the acute phase of symptomatic relief. The continued use of back braces could lead to de-conditioning of the spinal muscles. The clinical documentation submitted for review failed to indicate that the injured worker had spinal instability. There was a lack of documentation of exceptional factors to warrant non-adherence to the guideline recommendations. Given the above, the retrospective request for 1 Lumbo-Sacral Orthosis (LSO) brace between 03/21/2013 and 12/20/2013 is not medically necessary.

**RETROSPECTIVE REQUEST FOR ONE HOME LUMBAR TRACTION UNIT
BETWEEN 3/21/13 AND 12/2013: Upheld**

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES, LOW BACK- LUMBAR AND THORACIC (ACUTE & CHRONIC).

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, TRACTION.

Decision rationale: The Official Disability Guidelines (ODG) do not recommend using power traction devices, but home-based patient-controlled gravity traction may be a noninvasive conservative option if used as an adjunct to a program of evidence-based conservative care to achieve functional restoration. The clinical documentation submitted for review failed to indicate that the injured worker would be utilizing the device as an adjunct to a program of evidence-based conservative care. Additionally, the request as submitted failed to indicate what type of device was being requested and the duration of use. The request as submitted failed to indicate if the unit was for purchase or rental. Given the above, the retrospective request for 1 home lumbar traction unit between 03/21/2013 and 12/20/2013 is not medically necessary.