

<b>Case Number:</b>	CM15-0106260		
<b>Date Assigned:</b>	06/10/2015	<b>Date of Injury:</b>	01/27/2010
<b>Decision Date:</b>	08/19/2015	<b>UR Denial Date:</b>	05/11/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/02/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

### 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 51 year old male, who sustained an industrial injury on 1/27/10. The injured worker was diagnosed as having low back pain and sciatica. Treatment to date has included oral medications, 4 epidural injections, physical therapy, H-wave and home exercise program. Currently, the injured worker complains of intermittent aching pain in the bilateral aspects of the lower lumbar spine with radiation down the right lower extremity; he rates the pain 3- 5/10. He is working full time without restrictions. He has reported prior good results and functional gain with H-wave for pain management without narcotics. Physical exam noted tenderness over the PSM from L3-4 to L5 bilaterally with limited lumbar range of motion, hamstrings tightness and tenderness over right SI joint. A request for authorization was submitted for 8 physical therapy visits, 8 acupuncture visits, (MRI) magnetic resonance imaging of lumbar spine and H-Wave unit repair.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI of the lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**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, MRIs (magnetic resonance imaging).

**Decision rationale:** Regarding the request for lumbar MRI, CA MTUS does not address repeat imaging. ODG cites that repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. Within the documentation available for review, there is no identification of any red flags or objective findings that identify specific nerve compromise on the neurologic exam. Furthermore, there is no documentation of a significant change in symptoms and/or findings suggestive of significant pathology since prior imaging. In the absence of clarity regarding those issues, the currently requested lumbar MRI is not medically necessary.

**Physical therapy 8 visits low back, sciatica:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), physical therapy.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-99 of 127. Decision based on Non-MTUS Citation ODG, Low Back Chapter, Physical Medicine.

**Decision rationale:** Regarding the request for physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course (10 sessions) of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, while there is nonspecific mention of pain relief and improved function from prior therapy, there is no documentation of specific objective functional improvement with any previous sessions and remaining deficits that cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. In light of the above issues, the currently requested physical therapy is not medically necessary.

**Acupuncture 8 visits:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Acupuncture Treatment Guidelines.

**Decision rationale:** Regarding the request for acupuncture, California MTUS does support the use of acupuncture for chronic pain. Acupuncture is recommended to be used as an adjunct to physical rehabilitation and/or surgical intervention to hasten functional recovery. Additional use is supported when there is functional improvement documented, which is defined as "either a clinically significant improvement in activities of daily living or a reduction in work restrictions and a reduction in the dependency on continued medical treatment." A trial of up to 6 sessions is recommended, with up to 24 total sessions supported when there is ongoing evidence of functional improvement. Within the documentation available for review, it appears

the patient has undergone acupuncture previously. It is unclear how many sessions have previously been provided. Additionally, there is no documentation of objective functional improvement as outlined above. As such, the currently requested acupuncture is not medically necessary.

**H-wave home unit:** 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 Page(s): 114, 117-118 of 127.

**Decision rationale:** Regarding the request for H-wave unit, Chronic Pain Medical Treatment Guidelines state that electrotherapy represents the therapeutic use of electricity and is another modality that can be used in the treatment of pain. Guidelines go on to state that H-wave stimulation is 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, 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 and medications plus transcutaneous electrical nerve stimulation. Within the documentation there is not indication that the patient has a condition for which H-wave is supported. Furthermore, there is no indication of failure of a TENS trial as outlined by the CA MTUS as well as having undergone a subsequent H-wave trial with specific quantified pain relief, functional improvement, decreased use of pain medication, etc. In the absence of such documentation, the currently requested H-wave unit is not medically necessary.