

<b>Case Number:</b>	CM15-0051136		
<b>Date Assigned:</b>	03/24/2015	<b>Date of Injury:</b>	03/16/2006
<b>Decision Date:</b>	05/13/2015	<b>UR Denial Date:</b>	02/20/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/18/2015

### 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

### 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 59-year-old male who reported an injury on 03/16/2006. The mechanism of injury was not specifically stated. The current diagnoses include lumbar sprain/strain, lumbar paraspinal muscle spasm, and sacroiliitis of the right sacroiliac joint. The injured worker presented on 02/04/2015 for an initial pain management consultation. The injured worker reported persistent low back pain with radiating symptoms into the right lower extremity. It was noted that the injured worker had been previously treated with physical therapy, chiropractic manipulation, and medication management. Upon examination of the lumbar spine, there was moderate guarding, a loss of normal lumbar lordosis, severe pain over the right sacroiliac joint, positive sacroiliac joint test, positive Gaenslen's sign, positive Faber test, limited range of motion, severely positive straight leg raise on the right at 25 degrees, a mildly limping gait, diminished motor strength on the right, positive Trendelenburg test, positive Valsalva maneuver, sciatic notch tenderness, and intact sensation. Recommendations at that time included an MRI of the lumbar spine and left shoulder, an H-wave unit, and a referral for evaluation of the left shoulder. A Request for Authorization form was then submitted on 02/17/2015.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI of L spine:** 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) Low Back Chapter, MRI's.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state if physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test. In this case, it is noted that the injured worker underwent a previous MRI of the lumbar spine which clearly noted pathology consistent with subjective and objective findings. There is no evidence of a worsening or progression of symptoms or examination findings to support the necessity for a repeat MRI. Given the above, the request is not medically appropriate.

**MRI of left shoulder:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-209.

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state for most patients with shoulder problems, special studies are not needed unless a 4 to 6 week period of conservative care and observation fails to improve symptoms. There was no comprehensive physical examination of the left shoulder provided for review. Therefore, the medical necessity for an MRI of the left shoulder has not been established. In addition, there was no mention of an exhaustion of conservative treatment for the left shoulder. Given the above, the request is not medically appropriate.

**Referral:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM for Independent Medical Examinations and Consultations regarding Referrals, Chapter 7.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 89-92.

**Decision rationale:** California MTUS/ACOEM Practice Guidelines state a referral may be appropriate if the practitioner is uncomfortable with the line of inquiry, with treating a particular cause of delayed recovery, or has difficulty obtaining information or an agreement to a treatment plan. The specific type of referral was not listed in the request. Although the provider noted in the progress report the referral was for the left shoulder, there was no mention of an exhaustion

of conservative treatment nor evidence of a comprehensive physical examination of the left shoulder. The medical necessity has not been established. As such, the request is not medically appropriate.

**H-Wave unit 3 month rental and supplies:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines H-wave stimulation (HWT).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**Decision rationale:** California MTUS Guidelines state H-wave stimulation is not recommended as an isolated intervention, but a 1 month home-based trial of H-wave stimulation may be considered as a non-invasive conservative option for diabetic neuropathic pain or chronic soft tissue inflammation. H-wave stimulation should be used as an adjunct to a program of evidence based functional restoration and only following failure of initially recommended conservative care, including physical therapy, medications, and TENS therapy. In this case, it was noted that the injured worker had failed to respond to physical therapy, chiropractic manipulation, and medications. However, there was no evidence of a failure of treatment with a TENS unit. Additionally, the California MTUS Guidelines only recommend a 1 month trial. Therefore, the request for a 3 months rental would exceed guideline recommendations. As such, the request is not medically appropriate.