

Case Number:	CM13-0012054		
Date Assigned:	04/16/2014	Date of Injury:	12/05/1986
Decision Date:	05/07/2014	UR Denial Date:	08/07/2013
Priority:	Standard	Application Received:	08/16/2013

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 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 66 year-old female employee sustained an injury on 12/5/1986 while employed by the [REDACTED]. Surgical history include status post thoracolumbar fusion T3-S1 with instrumentation (unstated date). The patient had recent right SI joint injection on 11/21/12 along with extensive other previous conservative care to include medications, activity modification, and home exercise. Per utilization report, no diagnostic studies were provided for review. Report of 6/4/13 from the provider noted patient with low back pain exacerbation with recommendation for trial of TENS unit as well as SI joint injections noting the patient had prior good relief from previous epidural injections in the back and would like to repeat the procedure. Report of 7/9/13 noted exam showing full and symmetric muscle strength with hypesthesia in S1 distribution to 50% normal. There is an appeal letter from the provider dated 7/24/13 noting patient status post lumbar fusion T3-S1; has continued lumbosacral radiating pain and paresthesias of the feet; had prior good benefit for epidurals to lumbar spine and SI joints with 50% relief for a period of 6 months.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS UNIT PURCHASE: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 116.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 114-117.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines indicate that specified criteria for the use of TENS Unit includes trial in addition to ongoing treatment modalities within the functional restoration approach as appropriate for documented chronic intractable pain of at least three months duration with failed evidence of other appropriate pain modalities tried such as medication. It appears the patient has received extensive conservative treatment to include medications, modified work and rest, and physical therapy along with injections. There is no documentation on what TENS unit is to be purchased, its functional improvement from treatment trial, nor is there any documented short-term or long-term goals of treatment with the TENS unit. Submitted reports have not adequately addressed or demonstrated any functional benefit or pain relief as part of the functional restoration approach to support the request for the TENS Unit. There is no evidence for change in functional status, increased in ADLs, decreased VAS score, medication usage, or treatment utilization from the treatment already rendered. The TENS unit purchase is not medically necessary and appropriate.

BILATERAL L5-A1 TFESI (TRANSFORAMINAL EPIDURAL STEROID INJECTION):
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

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

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines recommend ESI as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy); however, radiculopathy must be documented on physical examination and corroborated by imaging studies and/or Electrodiagnostic testing, which has not been provided in this case. Submitted reports and diagnostics have not demonstrated any correlating neurological deficits to support repeating the epidural injections. Although the provider reported 50% improvement post previous injections, the patient continues with unchanged symptom severity, unchanged clinical findings without decrease in medication profile, treatment utilization or functional improvement described in terms of increased rehabilitation status or activities of daily living for this chronic 1986 injury. Criteria for repeating the epidurals have not been met or established. The BILATERAL L5-S1 TFESI (TRANSFORAMINAL EPIDURAL STEROID INJECTION) is not medically necessary and appropriate.