

Case Number:	CM13-0013957		
Date Assigned:	06/06/2014	Date of Injury:	10/13/2006
Decision Date:	07/29/2014	UR Denial Date:	07/22/2013
Priority:	Standard	Application Received:	08/26/2013

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 Anesthesia, has a subspecialty in Acupuncture & 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:

A 52 year old male injured worker with date of injury 10/13/06 with related low back pain. Per 4/14/14 progress report, the injured worker described his lumbar spine pain as 7/10 in severity with left greater than right radiculopathy; cervical spine pain rated 7/10; and right greater than left shoulder discomfort. He reported low back pain with radiation to the right hip and groin, with intermittent numbness in both feet. Neck pain and upper/mid back pain radiated to the upper extremities, greater to the right with numbness in the right thumb and radial forearm. Bilateral wrist and hand pain, numbness and weakness, right greater than left. Per physical exam straight leg raise test was positive to the right at 70 degrees in sitting position; it was negative on the left. MRI of the cervical spine dated 9/8/12 revealed 1-2mm disc osteophyte complexes at C3-C4 and C4-C5 with partial narrowing of the thecal sac. Treatment to date has included physical therapy, lumbar trigger point injection, and medication management. The date of UR decision was 7/22/13.

IMR ISSUES, DECISIONS AND RATIONALES

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

RS4I STIMULATOR VEST FOR PURCHASE: Overturned

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118.

Decision rationale: With regard to interferential current stimulation, MTUS states: "Not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone." "While not recommended as an isolated intervention, Patient selection criteria if Interferential stimulation is to be used anyway: Possibly appropriate for the following conditions if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine: - Pain is ineffectively controlled due to diminished effectiveness of medications; or - Pain is ineffectively controlled with medications due to side effects; or - History of substance abuse; or - Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or - Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). If those criteria are met, then a one-month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits. There should be evidence of increased functional improvement, less reported pain and evidence of medication reduction. A "jacket" should not be certified until after the one-month trial and only with documentation that the individual cannot apply the stimulation pads alone or with the help of another available person." Per the documentation submitted for review it is noted that RS-4i stimulation has proven very helpful and that the patient has been able to use less pain medication because of it. It is noted that he cannot reach his back to apply the pads, thus the request for stimulator vest. I respectfully disagree with the UR physician's assertion that the RS-4i stimulator utilizes NMES, which is not recommended by MTUS. Per MTUS and the product website, the device uses interferential current stimulation, which is not recommended as an isolated intervention. As the intervention is being used in conjunction with medications, and has subsequently reduced the usage of pain medications, the request is medically necessary as it is noted the injured worker cannot apply pads manually.

LEFT TRANSFORAMINAL EPIDURAL INJECTION AT L4-5: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines Page(s): 46.

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

Decision rationale: Per the MTUS CPMTG epidural steroid injections are used to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs and avoiding surgery, but this treatment alone offers no significant long-term benefit. The criteria for the use of epidural steroid injections are as follows: 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). 3) Injections should be performed using fluoroscopy (live x-ray) for guidance. 4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first

block. Diagnostic blocks should be at an interval of at least one to two weeks between injections.5) No more than two nerve root levels should be injected using transforaminal blocks.6) No more than one interlaminar level should be injected at one session.7) In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007)8) Current research does not support "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections. The documentation submitted for review contains physical exam findings of radiculopathy in the form of weakness to the upper extremities. No sensory deficit was noted. The documentation does not contain MRI findings that corroborate findings of radiculopathy. As the first criteria are not met, the request is not medically necessary.