

Case Number:	CM13-0070558		
Date Assigned:	01/08/2014	Date of Injury:	07/12/2010
Decision Date:	04/29/2014	UR Denial Date:	11/20/2013
Priority:	Standard	Application Received:	12/24/2013

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 Anesthesiology; has a subspecialty in Pain Medicine and is licensed to practice in Florida. 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 patient is a 63-year-old male who reported an injury on July 12, 2010. The mechanism of injury involved heavy lifting. The patient was diagnosed with lumbar disc disease and lumbar radiculopathy. The patient was seen by [REDACTED] on October 22, 2013. The patient reported ongoing pain to bilateral shoulders as well as 9/10 lower back pain with left leg numbness and tingling. Physical examination on that date revealed an antalgic gait, diffuse tenderness to palpation, moderate facet tenderness at L4-S1, positive Kemp's testing bilaterally, positive straight leg raise on the left and intact sensation with the exception of the L5 and S1 dermatomes. Treatment recommendations included a left L5-S1 and left S1 transforaminal epidural steroid injection as well as a lumbar traction unit.

IMR ISSUES, DECISIONS AND RATIONALES

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

LEFT L5-S1 AND LEFT S1 TRANSFORAMINAL EPIDURAL STEROID INJECTIONS:
Upheld

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

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

Decision rationale: The California MTUS Guidelines state epidural steroid injections are recommended as an option for the treatment of radicular pain, with use in conjunction with other rehab efforts. As per the documentation submitted, there was evidence of decreased sensation and diminished reflexes on the left. However, there were no imaging studies or electrodiagnostic reports submitted for review to corroborate a diagnosis of radiculopathy. There was no indication of unresponsiveness to conservative treatment. It is also noted that the patient has responded well to a previous epidural steroid injection. However, there was no documentation of 50% pain relief with an associated reduction of medication use for 6 to 8 weeks following the initial injection. Therefore, ongoing treatment cannot be determined as medically appropriate. Based on the clinical information received, the request is non-certified.

HOME LUMBAR TRACTION UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-301. Decision based on Non-MTUS Citation ODG (Low Back Chapter)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298-300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Traction

Decision rationale: The California MTUS/ACOEM Practice Guidelines state physical modalities have no proven efficacy in treating acute low back symptoms. The Official Disability Guidelines do not recommend using powered traction devices, but home-based, patient-controlled gravity traction is recommended as a noninvasive conservative option, if used as an adjunct to a program of conservative care to achieve functional restoration. As per the documentation submitted, the patient's physical examination of the lumbar spine does reveal diffuse tenderness to palpation, positive nerve root tension testing, slightly diminished lumbar range of motion, decreased sensation and decreased reflexes on the left. The patient has been instructed to continue with an aggressive home exercise program. While home-based, patient-controlled gravity traction may be considered as a noninvasive conservative option for this patient, the current request does not specify whether a powered traction device or patient-controlled gravity traction device is being requested. Therefore, the current request cannot be determined as medically appropriate. As such, the request is non-certified.