

Case Number:	CM14-0014247		
Date Assigned:	02/26/2014	Date of Injury:	04/24/2002
Decision Date:	08/04/2014	UR Denial Date:	01/07/2014
Priority:	Standard	Application Received:	02/04/2014

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 Occupational 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:

The patient is a 63-year-old female who has submitted a claim for lumbar disc disease, lumbar radiculopathy, lumbar facet syndrome, right sacroiliac joint arthropathy, left hip sprain/strain, and right knee sprain/strain; associated with an industrial injury date of 04/24/2002. Medical records from 2011 to 2013 were reviewed and showed that patient complained of back pain, graded 9-10/10, radiating down the left leg and calf. Physical examination showed and antalgic gait to the left. Tenderness over the lumbar paravertebral musculature and sacroiliac joints, and facet tenderness were noted at L4-S1. Lumbar range of motion was limited. Straight leg raise test was positive on the left. Kemp's, Patrick's, Yeoman's, Farfan's, and sacroiliac thrust tests were positive bilaterally. The patient's deep tendon reflexes were 1+ at the bilateral ankles. Motor testing showed weakness of the big toe extensors. Sensation was intact except over the left L5-S1 dermatome. Magnetic resonance imaging (MRI) of the lumbar spine, dated 11/28/2011, showed mild right L4-L5 neuroforaminal narrowing, and moderate bilateral neuroforaminal narrowing. Treatment to date has included medications, acupuncture, chiropractic therapy, physical therapy, and epidural steroid injections. Utilization review, dated 01/07/2014, denied the requests for epidural steroid injection and EMS unit. The reasons for denial were not made available.

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
2: Upheld**

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines EPIDURAL STEROID INJECTIONS (ESIs).

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

Decision rationale: As stated on page 46 of the California Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines, epidural steroid injections (ESI) are recommended as an option for treatment of radicular pain. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Also, the patient must be initially unresponsive to conservative treatment. 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 6 to 8 weeks. In this case, the patient complains of back pain accompanied by radicular symptoms despite medications, physical therapy, and other treatment modalities. Physical examination showed hyporeflexia of the bilateral ankles, weakness of the big toe extensors, hypoesthesia over the L5-S1 dermatome, and positive sacroiliac and sciatic nerve tension tests. Magnetic resonance imaging (MRI) of the lumbar spine, dated 11/28/2011, showed moderate bilateral neuroforaminal narrowing at L5-S1. However, the patient has had three previous ESIs on 05/08/2012, 07/10/2012, and 09/27/2012; and there was no discussion regarding percent pain relief, reduction of medication intake, or functional improvement from the procedure. The criteria for ESI have not been met. Therefore, the request left L5-S1 and left S1 transforaminal epidural steroid injections # 2 is not medically necessary.

ELECTRONIC MUSCLE STIMULATOR (EMS) UNIT: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines INTERFERENTIAL CURRENT STIMULATION (ICS)/TENS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 114-121.

Decision rationale: As stated on page 114 of the California Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines, transcutaneous electrotherapy is the most common form of electrotherapy where electrical stimulation is applied to the surface of the skin. It is not recommended as an isolated intervention but is an adjunct for recommended treatments including return to work, exercise, and medications. A one-month trial should be done given that the patient's pain is ineffectively controlled. Page 114 discusses TENS as opposed to multiple other devices. It is not recommended as a primary treatment modality, but a trial may be considered if used with functional restoration program. However, current evidence regarding long-term effectiveness is inconclusive. Page 121 states that there are no intervention trials suggesting benefit from neuromuscular electric stimulator for chronic pain; hence, it is not recommended unless following stroke. In this case, the patient presented with chronic back pain with radicular symptoms despite medications, TENS, and other treatment modalities. However, medical records submitted for review did not clearly reflect the duration of TENS use, or show evidence of functional benefit from its use. Moreover, there is no discussion regarding

concurrent functional restoration program. Therefore, the request for Electronic Muscle Stimulator (EMS) Unit is not medically necessary.