MAXIMUS Federal Services

Case Number:	CM14-0015157		
Date Assigned:	02/28/2014	Date of Injury:	11/20/2008
Decision Date:	08/07/2014	UR Denial Date:	01/15/2014
Priority:	Standard	Application Received:	02/06/2014

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 Physical Medicine and Rehabilitation, Pain Medicine and is licensed to practice in Texas. 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 injured worker is a 45 year old male whose date of injury is 11/20/08. The mechanism of injury is described as lifting heavy bags. Lumbar magnetic resonance image dated 08/10/11 revealed posterior annular tear at L4-5, disc desiccation at L4-5 and L5-S1, lateral recesses are encroached bilaterally at L4-5 with bilateral facet and ligamentum flavum hypertrophy. There is diffuse disc extrusion at L5-S1 effacing the thecal sac and projecting posteriorly. Re-evaluation dated 12/16/13 indicates that treatment to date includes 4 sessions of physical therapy as well as a home transcutaneous electrical nerve stimulation (TENS) unit which was helpful. Progress note dated 01/27/14 indicates that the injured worker complains of low back pain, right leg pain and right leg numbness. Diagnosis is L4-5, L5-S1 discogenic back pain with facet syndrome, disc protrusion, right lower extremity radiculopathy.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS UNIT AND SUPPLIES: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

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

Decision rationale: Based on the clinical information provided, the request for transcutaneous electrical nerve stimulation (TENS) unit and supplies is not recommended as medically necessary. The submitted records indicate that the injured worker previously utilized a home TENS unit; however, the injured worker's objective functional response to the unit is not documented to establish efficacy of treatment as required by California Medical Treatment Utilization Schedule guidelines. There is no current, detailed physical examination submitted for review and no specific, time-limited treatment goals were provided.

EVALUATION FOR PAIN MANAGEMENT: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines (chapter not specified), page 116.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, Chapter 7, page 127.

Decision rationale: Based on the clinical information provided, the request for evaluation for pain management is not recommended as medically necessary. There is no clear rationale provided to support the request at this time. It is unclear how the evaluation for pain management will aid in the diagnosis, prognosis, therapeutic management, determination of medical stability, and permanent residual loss and/or the examinee's fitness for return to work as required by American College of Occupational and Environmental Medicine Guidelines.

EPIDURAL: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

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

Decision rationale: Based on the clinical information provided, the request for epidural is not recommended as medically necessary. The request is nonspecific and does not indicate the level, laterality or approach for the requested injection. There is no current, detailed physical examination submitted for review to establish the presence of active radiculopathy as required by California Medical Treatment Utilization Schedule guidelines. There is no comprehensive assessment of treatment completed to date or the injured worker's response thereto submitted for review.

FACET INJECTIONS: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM Guidelines, page 300.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Facet joint diagnostic blocks (injections).

Decision rationale: Based on the clinical information provided, the request for facet injections is not recommended as medically necessary. The request is nonspecific and does not indicate the level or laterality for the requested injection. There is no current, detailed physical examination submitted for review to establish the presence of facet-mediated pain as required by the Official Disability Guidelines. There is no comprehensive assessment of treatment completed to date or the injured worker's response thereto submitted for review.