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| Case Number: | CM14-0041290 | | |
| Date Assigned: | 06/27/2014 | Date of Injury: | 02/07/2012 |
| Decision Date: | 08/18/2014 | UR Denial Date: | 03/27/2014 |
| Priority: | Standard | Application Received: | 04/07/2014 |

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 Preventative Medicine, has a subspecialty in Occupational Medicine and is licensed to practice in Iowa. 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 patient is a 39 year old employee with date of injury of 2/7/2012. Medical records indicate the patient is undergoing treatment for thoracic and lumbar neuritis radiculopathy, lumbar myospasm, left sacroiliac (SI) joint dysfunction and displaced lumbar intervertebral disc. Subjective complaints include constant severe pain on left side, increase in pain when walking or sitting for long periods of time, and insomnia. She requests pain medication stronger than Norco. Objective findings include: left spine range of motion (ROM) of flexion to 30 and extension to 20; lateral flexion Left & Right to 25; tender left SI joint; positive left figure-4 test; minimal facet joint tenderness; slight difficulty toe walk; positive bilateral straight leg raise to 50; motor weakness in hamstring and plantar flexors; no noticeable reflex deficits in achilles and patella bilaterally; and tender PV muscles in lumbar spine. Treatment includes Norco, Xanax, Tizadine, Epidural Steroid Facet Injection, Alprazolam and Carisoprodol. The utilization review determination was rendered on 3/27/2014 recommending non-certification of 1 TENS unit with 1 month supply electrodes; outpatient lumbar epidural steroid facet injection at l5-s1 and outpatient physical therapy to lumbar 3 times per week for 2 weeks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient lumbar epidural steroid facet injection at L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of Epidural Steroid Injections.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315, Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Epidural steroid injections (ESIs), therapeutic Other Medical Treatment Guideline or Medical Evidence: MD Guidelines, Facet Joint Injections/Therapeutic Facet Joint Injections.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines state that epidural steroid injections are recommended as an option for treatment of radicular pain and provide short term pain relief. They should be in conjunction with other rehab efforts including a home exercise program. The MTUS further defines the criteria for epidural steroid injections to include, radiculopathy documented by physical examination and corroborated by imaging studies and / or electrodiagnostic testing; initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants); a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block; and 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. In addition, Official Disability Guidelines (ODG) and MD Guidelines agree that one diagnostic facet joint injection may be recommended for patients with chronic low back pain that is significantly exacerbated by extension and rotation. Furthermore, the pain should be associated with lumbar rigidity and not alleviated with other conservative treatments (e.g., NSAIDs, aerobic exercise, other exercise, manipulation) in order to determine whether specific interventions targeting the facet joint are recommended. If after the initial block/blocks are given and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks, additional blocks may be supported. The treating physician does document 50% pain relief from a previous epidural steroid injection, however, does not provide details how long the patient got relief from the injection. Additionally, the treating physician does not document radiculopathy on physical examination and on medical imaging. As such, the request for Lumbar Epidural Steroid Facet Injection at L5-S1 is not medically necessary.

Purchase of 1 TENS unit with 1 month supply electrodes: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of TENS: Chronic Intractable Pain.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315, Chronic Pain Treatment Guidelines Interferential Current Stimulation, Transcutaneous electrotherapy Page(s): 54, 114-116, 118-120.

Decision rationale: ACOEM guidelines state insufficient evidence exists to determine the effectiveness of sympathetic therapy, a noninvasive treatment involving electrical stimulation, also known as interferential therapy. At-home local applications of heat or cold are as effective as those performed by a therapist. MTUS further states that they are not recommended as an isolated intervention and further detail possible criteria for selection. For example: pain is ineffectively controlled due to diminished effectiveness or side effects of medications; history of

substance abuse; significant pain from postoperative conditions that limits the ability to perform exercise programs or physical therapy treatment; or unresponsive to conservative measures. If those criteria are met, then a one-month trial may be appropriate to permit the physician to study the effects and benefits. The treating physician's progress notes do not indicate that the patient has poorly controlled pain, concerns for substance abuse, pain from postoperative conditions that limit ability to participate in exercise programs/treatments, or is unresponsive to conservative measures. As such, current request for Interferential Unit is not medically necessary.

Outpatient physical therapy to lumbar 3 times per week for 2 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315, Chronic Pain Treatment Guidelines Physical Therapy, Physical Medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Physical Therapy.

Decision rationale: The California MTUS guidelines refer to physical medicine guidelines for physical therapy. Recommendations are as follows: allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home physical medicine. Additionally, ACOEM guidelines advise against passive modalities by a therapist unless exercises are to be carried out at home by the patient. Official Disability Guidelines (ODG) quantifies its recommendations with 10 visits over 8 weeks for lumbar sprain/strains and 9 visits over 8 weeks for unspecified backache/lumbago. ODG further states that a six-visit clinical trial of physical therapy with documented objective and subjective improvements should occur initially before additional sessions are to be warranted. The treating physician has not provided evidence of a home exercise program, number of previously completed physical therapy sessions and the outcome of those sessions. Additionally, the treating physician has not provided medical documentations to justify additional physical therapy at this time. As such, the request for outpatient physical therapy to the lumbar 3 times a week for 2 weeks is not medically necessary.