

Case Number:	CM14-0061514		
Date Assigned:	07/09/2014	Date of Injury:	03/14/2000
Decision Date:	09/15/2014	UR Denial Date:	04/25/2014
Priority:	Standard	Application Received:	05/02/2014

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, and lumbar facet syndrome; associated with an industrial injury date of 03/14/2000. Medical records from 2013 to 2014 were reviewed and showed that patient complained of mid/low back pain with radicular symptoms. Pain is increased with lifting, bending, stooping, and prolonged sitting and weight-bearing. Physical examination showed tenderness over the lumbosacral junction, bilateral paravertebral musculature, and over the bilateral sciatic notches. Straight leg raise test was positive bilaterally. Range of motion of the lumbar spine was limited. DTRs were normal. Motor testing showed weakness of the bilateral hip flexors, knee extensors, and big toe extensors. Sensation was decreased along the bilateral L4-L5 and S1 dermatomes. MRI of the lumbar spine, dated 02/14/2014, showed mild to moderate right and mild left L4-L5 foraminal encroachment, and mild to moderate bilateral L5-S1 foraminal encroachment. Treatment to date has included medications, psychotherapy, physical therapy, and home exercise program. Utilization review, dated 04/25/2014, denied the request for epidural steroid injection because the requisite criteria for radiculopathy for Epidural Steroid Injection was not met; and denied the request for interferential unit because there was no documentation of objective measures of success such as medication reduction, objective functional improvement or the like out of a TENS trial, or that the use will be part of an evidence-based functional restoration program.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral L4-L5 and L5-S1 transforaminal epidural steroid injection: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid Injections. Decision based on Non-MTUS Citation AMA guides, 5h Edition pg 382-383.

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 CA 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 and conservative therapy. Physical examination showed a bilaterally positive straight leg raise test, weakness of the bilateral lower extremities, and hypoesthesia over the L4, L5, and S1 dermatomal distributions. MRI of the lumbar spine, dated 02/14/2014, showed mild to moderate right and mild left L4-L5 foraminal encroachment, and mild to moderate bilateral L5-S1 foraminal encroachment. The criteria for ESI have been met. Therefore, the request for Transforaminal Epidural Steroid Injection Bilateral L4-L5-S1 is medically necessary.

Interferential Unit: Upheld

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): 118-119.

Decision rationale: As stated on pages 118-119 on the CA MTUS Chronic Pain Medical Treatment Guidelines, interferential current stimulation is 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. In this case, the patient complains of back pain with radicular symptoms despite medications and conservative treatment. The current plan is to use the interferential unit in conjunction with medications, self-guided pool exercises and a home exercise program. However, the present request as submitted failed to specify whether approval for the interferential unit was for rental or purchase. Therefore, the request for Interferential Unit is not medically necessary.

