

Case Number:	CM14-0063554		
Date Assigned:	07/11/2014	Date of Injury:	09/12/2013
Decision Date:	09/25/2014	UR Denial Date:	04/22/2014
Priority:	Standard	Application Received:	05/06/2014

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, has a subspecialty in Pain Management 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:

This is a patient with a date of injury of 9/12/13. A utilization review determination dated 4/22/14 recommends non-certification of ESI, cold therapy unit, and electrotherapy unit. 4/14/14 medical report identifies pain in the bilateral shoulders, neck, and low back, as well as headaches. On exam, there is positive impingement sign in the bilateral shoulders and tenderness over the medial border of the scapula. Treatment plan includes evaluation by psychiatry and authorization for ESI with continued follow-up with pain management. 3/27/14 medical report identifies upper and lower back pain with RLE pain, numbness, and weakness. On exam, there is limited lumbar ROM with tenderness over the facet area, positive SLR on the right, and unquantified weakness in flexion and dorsiflexion of the right foot compared to the left. An ESI was recommended. The provider also recommended a cold therapy unit purchase and combo-STIM electrotherapy to be utilized post-injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right sided L5-S1 transforaminal epidural steroid injection under fluoroscopic guidance.:
Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20-9792.26; Epidural steroid injections (ESIs) Page(s): 46 of 127.

Decision rationale: Regarding the request for epidural steroid injection, Chronic Pain Medical Treatment Guidelines state that epidural injections are recommended as an option for treatment of radicular pain, defined as pain in dermatomal distribution with corroborative findings of radiculopathy, and failure of conservative treatment. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Within the documentation available for review, there are no consistent physical exam, imaging, and/or electrodiagnostic study findings suggestive of radiculopathy at the level proposed for injection. In the absence of such documentation, the currently requested epidural steroid injection is not medically necessary.

Motorized cold therapy unit: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Cold/Heat Packs.

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

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Combination stim-electrotherapy: 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 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 114-121 of 127.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.