

Case Number:	CM14-0088617		
Date Assigned:	06/23/2014	Date of Injury:	05/05/2013
Decision Date:	08/25/2014	UR Denial Date:	05/13/2014
Priority:	Standard	Application Received:	06/12/2014

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 and is licensed to practice in Nevada. 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 24-year-old male who was reportedly injured on May 5, 2013. The mechanism of injury was noted as a lifting event. The most recent progress note dated May 5, 2014, indicated that there were ongoing complaints of low back pain. The physical examination demonstrated no deformities of the cervical spine, a decrease in lumbar spine range of motion, the ability to heel and toe walk easily, and straight leg raising was reported to be negative. Motor function was under be 5/5 throughout the both lower extremities, and deep tendon reflexes were noted to be 1+. Diagnostic imaging studies were not reviewed. However, plain films reported no obvious pathology was noted. There was a reported disc lesion at L5-S1. Previous treatment included physical therapy, multiple medications, injection therapies and pain management techniques. A request was made for lumbar epidural steroid injection, acupuncture, interferential unit and was not certified in the pre-authorization process on May 13, 2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Acupuncture to the lumbar spine, 2 x 3: Upheld

Claims Administrator guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Acupuncture Treatment Guidelines.

Decision rationale: As noted in the acupuncture treatment guidelines, this is an option when pain medication is reduced or not tolerated. Neither of those parameters are as noted in the progress notes presented. Furthermore, a trial of 3-6 treatments are suggested to be completed within 2 months of the date of injury. That parameter was not noted. Therefore, based on the clinical information presented for review, the request is not medical necessary.

Lumbar epidural at L5-S1, bilateral: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines : 8 C.C.R. 9792.20 - 9792.26 (Effective July 18, 2009), page 46 of 127 Page(s): 46 OF 127.

Decision rationale: When noting the date of injury, the injury sustained, there was evidence of a disc herniation; however, it is not clear if this was inclusive nerve root. Furthermore, as outlined in the California Medical Treatment Utilization Schedule, such epidural steroid injections are only indicated when radiculopathy is documented and corroborated by both imaging and electrodiagnostic studies. There were no diagnostic studies presented for review. Based on the evidence presented. The request is not medically necessary.

Interferential unit, 3 month rental: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 120.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines : 8 C.C.R. 9792.20 - 9792.26 (Effective July 18, 2009), pages 118-120 of 127 Page(s): 118-120 of 127.

Decision rationale: As outlined in the California Medical Treatment Utilization Schedule, such a device is not recommended, as there is no qualitative evidence of the efficacy, effect in this or utility of such a device in controlling pain. When noting the date of injury, the mechanism of injury, the injury sustained and the current treatments being pursued, there was insufficient clinical evidence to support the medical necessity of such a device. Therefore, the request is not medically necessary.