

<b>Case Number:</b>	CM14-0202668		
<b>Date Assigned:</b>	12/15/2014	<b>Date of Injury:</b>	05/26/2014
<b>Decision Date:</b>	02/03/2015	<b>UR Denial Date:</b>	11/04/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/04/2014

### 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 Internal Medicine, has a subspecialty in Rheumatology, Allergy & Immunology 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:

This is a 38 year old male with a date of injury of 05/26/14. He is being treated for degenerative disc disease at L4-L5 and L5-S1 with left L5 and S1 radiculopathies. Subjective finding includes pain in low back radiating into his buttock and proximal thigh but not distal, worse with walking, better if he lays down. He denies any numbness, weakness or bowel/bladder incontinence. Objective findings include a normal physical exam for ambulation and no evidence of weakness. There was a normal lumbar spine x-ray with flexion and extension. On 07/18/14, his MRI report of the lumbar spine showed a 3 mm annular disc bulge at L4-L5 with central annular fissure and minimal narrowing of lateral recess. At L5-S1, there is a 4 mm left paramedian disc protrusion causing abutment of the left S1 nerve root and 3mm right lateral disc protrusion with mild narrowing of lateral recess and mild right sided foraminal narrowing. Treatments thus far have included physical therapy which is currently stopped, APAP, naprosyn and Decadron. The previous Utilization Review on 11/04/14 was non-certify for L4-5, L5-S1 epidural steroid injections as the documentation submitted had limited evidence of radiculopathy on exam correlated by imaging. The request for the TENS unit is non-certify based on lack of trial showing objective functional improvement and unclear indication for its use.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left L4-5, L5-S1 Epidural Steroid Injections:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs) .

**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.

**Decision rationale:** MTUS Chronic pain medical treatment guidelines state that epidural steroid injections are "Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) . . . Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program." There were no medical documents provided to conclude that other rehab efforts or home exercise program is ongoing. In fact, his physical therapy is currently stopped. Additionally, no objective findings were documented to specify the dermatomal distribution of pain. MTUS further defines the criteria for epidural steroid injections to include: 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). 3) Injections should be performed using fluoroscopy (live x-ray) for guidance.4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections.5) No more than two nerve root levels should be injected using transforaminal blocks.6) No more than one interlaminar level should be injected at one session.7) 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, with a general recommendation of no more than 4 blocks per region per year. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007)8) Current research does not support a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections. In this case, the radiculopathy does appear to be documented with imaging studies but is not corroborated by his current symptoms and physical exam with pain limited to thigh and buttock with no documented evidence of issues with sensation, weakness or DTRs. The patient had taken NSAIDS and been to physical therapy and appears to have responded to them and the most recent exacerbation is not a failure but a flare of his symptoms. Additionally, treatment notes do not indicate that there is ongoing home exercise or physical therapy. As such, the request for L4-L5 and L5-S1 Epidural Steroid Injection is not medically necessary.

**Transcutaneous Electrical Nerve Stimulation (TENS) unit with supplies:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation, Transcutaneous electrotherapy Page(s): 54, 114-116, 118-120.

Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, TENS chronic pain (transcutaneous electrical nerve stimulation).

**Decision rationale:** MTUS states regarding TENS unit, "Not recommended as a primary treatment modality, but a one-month home-based TENS trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration, for the conditions described below." For pain, MTUS and ODG recommend TENS (with caveats) for neuropathic pain, phantom limb pain and CRPSII, spasticity, and multiple sclerosis. The medical records do not indicate any of the previous conditions. ODG further outlines recommendations for specific body parts: Low back: Not recommended as an isolated intervention Knee: Recommended as an option for osteoarthritis as adjunct treatment to a therapeutic exercise program Neck: Not recommended as a primary treatment modality for use in whiplash-associated disorders, acute mechanical neck disease or chronic neck disorders with radicular findings Ankle and foot: Not recommended Elbow: Not recommended Forearm, Wrist and Hand: Not recommended Shoulder: Recommended for post-stroke rehabilitation Medical records do not indicate conditions of the low back, knee, neck, ankle, elbow, or shoulders that meet guidelines. ODG further details criteria for the use of TENS for Chronic intractable pain (for the conditions noted above): (1) Documentation of pain of at least three months duration (2) There is evidence that other appropriate pain modalities have been tried (including medication) and failed (3) A one-month trial period of the TENS unit should be documented (as an adjunct to ongoing treatment modalities within a functional restoration approach) with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function; rental would be preferred over purchase during this trial (4) Other ongoing pain treatment should also be documented during the trial period including medication usage (5) A treatment plan including the specific short- and long-term goals of treatment with the TENS unit should be submitted (6) After a successful 1-month trial, continued TENS treatment may be recommended if the physician documents that the patient is likely to derive significant therapeutic benefit from continuous use of the unit over a long period of time. At this point purchase would be preferred over rental. (7) Use for acute pain (less than three months duration) other than post-operative pain is not recommended. (8) A 2-lead unit is generally recommended; if a 4-lead unit is recommended, there must be documentation of why this is necessary. The medical records do not satisfy the several criteria for selection specifically, lack of documented 1-month trial, lack of documented short-long term treatment goals with TENS unit, and unit use for acute (less than three months) pain. As such, the request for 1 Tens Unit with supplies is not medically necessary.