

<b>Case Number:</b>	CM15-0148270		
<b>Date Assigned:</b>	08/11/2015	<b>Date of Injury:</b>	08/19/2014
<b>Decision Date:</b>	09/14/2015	<b>UR Denial Date:</b>	07/07/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/30/2015

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:  
 State(s) of Licensure: California, Hawaii  
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 55 year old male, who sustained an industrial injury on August 19, 2014. He reported a pain in his low back with the inability to bend over. The injured worker was diagnosed as having lumbosacroiliac strain, lumbar degenerative disc disease L5-S1 with S-1 radiculopathy, right sacroiliac joint dysfunction and chronic pain syndrome. Treatment to date has included diagnostic studies, medications and physical therapy. On July 13, 2015, the injured worker complained of pain in his lower back radiating to the right leg. The pain was rated as a 3-4 on a 1-10 pain scale. The pain is better with standing up and walking and worse with staying in one position for a long time. His opioid medication was noted to take the pain down to a 2 on the pain scale with pain relief lasting three hours. The treatment plan included medication, a thirty-day trial of interferential stimulator unit (meds-4), increasing fluid intake and a follow-up visit. On July 7, 2015, Utilization Review non-certified the request for lumbar epidural steroid injection right L5-S1 and interferential stimulator (meds-4 with garment), citing California MTUS ACOEM and Official Disability Guidelines.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lumbar epidural steroid injection right L5-S1: Overturned**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46.

**Decision rationale:** The patient presents with diagnoses that include lumbosacroiliac strain, lumbar degenerative disc disease L5-S1 with S-1 radiculopathy, right sacroiliac joint dysfunction and chronic pain syndrome. The patient currently complains of pain in his lower back radiating to the right leg. The current request is for lumbar epidural steroid injection right L5-S1. The treating physician states in the treating report dated 6/8/15 (28B), "Request authorization for lumbar epidural steroid injection right L5-S1." Later in the treating report dated 7/13/15 (19B), the treating physician states, "Will honor denial of ESI at this time, patient prefers to avoid injections at this time." Regardless of the fact that the patient/physician may have changed his/her mind regarding treatment the medical necessity of the requested treatment is still evaluated. MTUS Guidelines support the usage of ESI for the treatment of radicular pain that must be documented in physical examination and corroborated by diagnostic imaging - testing. Additionally, the radicular pain should be initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). Finally, 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. In this case, the clinical history provided meets and/or exceeds MTUS Guidelines. The clinical records document a history of radicular pain supported both by physical examination and corroborated by diagnostic imaging as noted in the MRI report dated 1/2/15 (50B). Additionally, the clinical history documents radicular pain, which was initially unresponsive to conservative treatment. Thus, the requested treatment is medically necessary.

**Interferential stimulator (meds-4 with garment):** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential current stimulation. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain Chapter.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation (ICS) Page(s): 118-120.

**Decision rationale:** The patient presents with diagnoses that include lumbosacroiliac strain, lumbar degenerative disc disease L5-S1 with S-1 radiculopathy, right sacroiliac joint dysfunction and chronic pain syndrome. The patient currently complains of pain in his lower back radiating to the right leg. The current request is for interferential stimulator (meds-4 with garment). The treating physician states in the treating report dated 7/13/15 (20B), "Request auth for 30 day trial of interferential stimulator unit (meds-4) to be used in combination with exercise and medication to improve daily function. Patient meets MTUS criteria, see details below." MTUS Guidelines state that Interferential (IF) current stimulation is not recommended as an isolated intervention. MTUS states that if criteria were met, then a one-month trial would be appropriate. MTUS goes

further to state that use of the IF unit would be appropriate under the following conditions if it has documented and proven to be effective as directed or applied by the physician or a provider licensed to provide physical medicine: Pain is ineffectively controlled due to diminished effectiveness of medications; or Pain is ineffectively controlled with medications due to side effects; or History of substance abuse; or Significant pain from postoperative conditions limits the ability to perform exercise programs/physical therapy treatment; or Unresponsive to conservative measures (e.g., repositioning, heat/ice, etc.). If the criteria are met, then a one-month trial may be appropriate to permit the physician and physical medicine provider to study the effects and benefits. There should be evidence of increased functional improvement; less reported pain and evidence of medication reduction. In this case, the supporting clinical history (28B) documents that "pain is ineffectively controlled with medications due to side effects," and that the patient is "unresponsiveness to conservative measures" and that the pain limits the patient's ADLs (34B). The current request is medically necessary.