

Case Number:	CM15-0041670		
Date Assigned:	03/11/2015	Date of Injury:	06/25/1998
Decision Date:	04/15/2015	UR Denial Date:	02/06/2015
Priority:	Standard	Application Received:	03/05/2015

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: New Jersey, New York
 Certification(s)/Specialty: Family Practice

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 42 year old female, who sustained an industrial injury on 6/25/98. She has reported back injury after lifting a 29 pound baby from a floor crib and she felt a sharp pain. The diagnoses have included lumbosacral neuritis and lumbar/lumbosacral degenerative disc disease (DDD). Treatment to date has included medications, physical therapy, diagnostics, Transcutaneous Electrical Nerve Stimulation (TENS), chiropractic, heat, ice, massage therapy, and Home Exercise Program (HEP). Currently, as per the physician progress note dated 1/20/15, the injured worker complains of intermittent low back pain with occasional numbness in the right leg. She has maintained a Home Exercise Program (HEP) as given to her from previous physical therapy. She has recently made an appointment with pain management for evaluation and possible injection therapy. The physical exam of the spine revealed discomfort in the paraspinal region exacerbated by forward flexion. There were tight hamstrings bilaterally. The current medications were not listed. There was previous therapy sessions noted. The physician noted that she previously has failed conservative management consisting of rest, anti-inflammatories, physical therapy and chiropractic. Treatment plan was for an upcoming appointment with pain management to discuss lumbar spine injections and follow up in six weeks. Work status was to return to work without restrictions as of 1/20/15.

IMR ISSUES, DECISIONS AND RATIONALES

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

Purchase of an Electrical Muscle Stimulator (EMS) Unit: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Neuromuscular electrical stimulation (NMES devices) Page(s): 121.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NMES Page(s): 121.

Decision rationale: The request is considered not medically necessary. According to MTUS, the use of NMES is not recommended. It is used primarily as part of a rehab program following stroke and there is no evidence to support the use of NMES in chronic pain. There is no documentation that the patient suffered from a stroke. Therefore the request is considered not medically necessary.

Nerve Root Block/Bilateral Lumbar Transforaminal Epidural Steroid Injection at S1 Level: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 45.

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

Decision rationale: The request for a bilateral transforaminal epidural steroid injection at S1 is not medically necessary. The guidelines state that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. The patient had positive straight leg raise but no documented sensory or motor deficits at S1. The patient has been treated with conservative measures and there was history of improvement with chiropractic care. Therefore, she did not fail to improve with conservative treatment modalities. Therefore, the request is considered medically unnecessary.

Compound Cream - Dosage, components, and quantity not indicated: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): 111-113.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical analgesics Page(s): 111.

Decision rationale: The request is medically unnecessary. The use of topical analgesics is largely experimental in use with few randomized controlled trials to determine efficacy or safety. They are primarily recommended for neuropathic pain when antidepressants and anticonvulsants have failed. There was no documentation that the patient was unable tolerate all oral analgesics. Because the components, dosage, directions, and quantities were not included, the request is considered not medically necessary.