

Case Number:	CM15-0050188		
Date Assigned:	03/19/2015	Date of Injury:	11/03/2011
Decision Date:	05/12/2015	UR Denial Date:	03/17/2015
Priority:	Standard	Application Received:	03/10/2015

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 York
 Certification(s)/Specialty: Anesthesiology

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 56 year old female, who sustained an industrial injury on 11/3/2011. She reported a low back injury. Diagnoses include lumbar sprain/strain, degeneration thoracic/lumbar disc, and L4-5 lateral recess stenosis. She is status post lumbar discogram completed 12/4/14. Treatments to date include medication therapy, physical therapy, chiropractic treatments, and acupuncture and epidural injections. Currently, they complained of low back pain with radiation to bilateral legs rated 7/10 VAS. On 2/27/15, the provider documented objective findings including tenderness to lumbar spine, decreased lumbar extension and lateral left bend, and positive straight leg raise test to left side. The plan of care included continuation of the home TENS unit, medication therapy, and a bilateral L4-5 lumbar epidural.

IMR ISSUES, DECISIONS AND RATIONALES

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

TENS Unit Qty: 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114-116.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines TENS Page(s): 114-121.

Decision rationale: According to the MTUS guidelines, the TENS unit is not recommended as a primary treatment modality. A one-month home-based trial may be considered as a noninvasive conservative option, if used as an adjunct to a program of evidence-based functional restoration for conditions such as, neuropathic pain, phantom limb pain, complex regional pain syndrome (CRPS), spasticity or multiple sclerosis (MS). The documentation indicates the patient had a benefit from the use of TENS in conjunction with physical therapy. CA MTUS states that a one-month trial period of the TENS unit should be documented with documentation of how often the unit was used, as well as outcomes in terms of pain relief and function. Rental is preferred over purchase during this trial. Medical necessity for the requested item is not established. The requested item is not medically necessary.

Norco 10/325mg #90: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 78-80, 91, 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 91-97.

Decision rationale: According to the CA MTUS and ODG, Norco 10/325mg (Hydrocodone/Acetaminophen) is a short-acting opioid analgesic indicated for moderate to moderately severe pain, and is used to manage both acute and chronic pain. The treatment of chronic pain with any opioid analgesic requires review and documentation of pain relief, functional status, appropriate medication use, and side effects. A pain assessment should include current pain, intensity of pain after taking the opiate, and the duration of pain relief. In this case, there is no documentation of the medication's functional benefit. Medical necessity of the requested item has not been established. Of note, discontinuation of an opioid analgesic should include a taper, to avoid withdrawal symptoms. The requested medication is not medically necessary.

Left L4-L5 Lumbar Epidural Steroid Injection: Upheld

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

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

Decision rationale: Epidural steroid injections (ESIs) are recommended as an option for treatment of radicular pain (defined as pain in a dermatomal distribution with corroborative findings of radiculopathy). Most current guidelines recommend no more than 2 ESI injections. Research has shown that, on average, less than two injections are required for a successful ESI outcome. ESIs can offer short-term pain relief and use should be in conjunction with other rehab

efforts. The purpose of ESIs is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months. CA MTUS guidelines state radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. The patient must be initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). In this case, the patient received a previous lumbar ESI with improvement of low back pain, but the duration of relief was not documented. Medical necessity for the requested left L4-L5 ESI has not been established. The requested ESI is not medically necessary.

Right L4-L5 Lumbar Epidural Steroid Injection: Upheld

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

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

Decision rationale: Epidural steroid injections (ESIs) are recommended as an option for treatment of radicular pain (defined as pain in a dermatomal distribution with corroborative findings of radiculopathy). Most current guidelines recommend no more than 2 ESI injections. Research has shown that, on average, less than two injections are required for a successful ESI outcome. ESIs can offer short-term pain relief and use should be in conjunction with other rehab efforts. The purpose of ESIs is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months. CA MTUS guidelines state radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. The patient must be initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). In this case, the patient received a previous lumbar ESI with improvement of low back pain, but the duration of relief was not documented. Medical necessity for the requested right L4-L5 ESI has not been established. The requested ESI is not medically necessary.

Fluoroscopy: 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 ESIs.

Decision rationale: The bilateral lumbar L4-L5 ESIs were found not to be medically necessary. Therefore, the medical necessity for fluoroscopy has not been established. The requested fluoroscopy is not medically necessary.