

Case Number:	CM14-0146478		
Date Assigned:	09/12/2014	Date of Injury:	02/11/2013
Decision Date:	10/14/2014	UR Denial Date:	08/04/2014
Priority:	Standard	Application Received:	09/09/2014

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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Florida. 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 60-year-old female who reported an injury on 02/11/2013 due to a fall. The injured worker has diagnoses of lumbar sprain/strain, lumbar paraspinal muscle spasms, disc herniation, and lumbar radiculitis/radiculopathy of the lower extremities. Past medical treatment consists of physical therapy, cervical epidural steroid injections, SI injections, the use of a lumbar rehab kit, and medication therapy. Medications include Duragesic patch 50 mcg. On 08/07/2014 the injured worker underwent an MRI of the lumbar spine without contrast, which revealed a 2 mm broad based disc bulge and moderate facet arthropathy of the L4-5 level. There was minimal narrowing of the central canal, mild foraminal narrowing on the right and moderate foraminal narrowing on the left. The MRI also revealed a 10 mm anterolisthesis at the L5-S1 level. There was moderate to severe facet arthropathy. On 08/13/2014 the injured worker complained of low back pain. Upon physical examination it was noted that the injured worker had a pain rate of 9/10. Range of motion of the lumbar spine was limited. It was also noted that there was weakness, along with tingling and numbness in both legs, with progressive complaints of pain. The medical treatment plan was for the injured worker to undergo transforaminal epidural steroid injection at L4-5 and L5-S1, receive the third sacroiliac joint injection, and percutaneous neurostimulator. The rationale and Request for Authorization form were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

First bilateral transforaminal epidural steroid injection at L4-5 and L5-S1 under fluoroscopic guidance: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines epidural steroid injections.

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

Decision rationale: The request for First bilateral transforaminal epidural steroid injection at L4-5 and L5-S1 under fluoroscopic guidance is not medically necessary. The California MTUS Guidelines recommend epidural steroid injection as an option for treatment of radicular pain. An 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 is no information on improved function. The criteria for the use of an epidural steroid injection are as follow: radiculopathy must be documented by physical examination and corroborated imaging studies, be initially unresponsive to conservative treatment, injections should be performed using fluoroscopy, and no more than 2 nerve root levels should be injected using transforaminal blocks. The progress note dated 08/13/2014 failed to show evidence of objective findings of radiculopathy, numbness, weakness, and loss of strength. There was no radiculopathy documented by physical examination. Additionally, the documentation also lacked any evidence of the injured worker having been initially unresponsive to conservative treatment, which would include exercise, physical methods and medications. The MRI obtained 08/07/2014 did reveal that the injured worker had mild foraminal narrowing on the right and moderate foraminal narrowing on the left at L4-5 and L5-S1. However, due to a lack of physical evidence, the injured worker is not within the MTUS recommended guidelines. As such, the request is not medically necessary.

Third left sacroiliac joint injection under fluoroscopic injection: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); therapeutic injections

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Hip & Pelvis Chapter, Sacroiliac joint blocks

Decision rationale: The request for Third left sacroiliac joint injection under fluoroscopic injection is not medically necessary. The Official Disability Guidelines recommend sacroiliac joint blocks when the history and physical suggest the diagnosis with documentation of at least 3 positive exam findings include the cranial shear test, extension test, flamingo test, Gaenslen's test, Gillette's test, Patrick's test, pelvic compression test, pelvic distraction test, pelvic rock test, resisted abduction test, sacroiliac shear test, standing flexion test, and a thigh thrust test. The diagnostic evaluation must first address any other possible pain generators and there should be documentation that the injured worker has had and failed at least 4 to 6 weeks of aggressive

conservative therapy including physical therapy, home exercise and medication management. In treatment or therapeutic phase, the suggested frequency for repeat blocks is 2 months or longer between each injection, provided that at least 70 percent pain relief is obtained for 6 weeks. The physical examination dated 08/13/2014 did not indicate that the injured worker had at least 3 of the above tests positive to suggest diagnosis. Furthermore, there was no indication in the submitted report that the injured worker had trialed and failed aggressive conservative therapy for at least 4 to 6 weeks. Given the above, the injured worker is not within ODG criteria. As such, the request is not medically necessary.

Percutaneous nerotimulator therapeutic treatments QTY: 4.00: 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 Percutaneous electrical nerve stimulation (PENS) Page(s): 97.

Decision rationale: The request for percutaneous neurostimulator therapeutic treatments QTY: 4.00 are not medically necessary. The California MTUS Guidelines do not recommend TENS unit as a primary treatment modality, but a trial may be considered, if used as an adjunct to a program of evidence based functional restoration; after other nonsurgical treatments, including therapeutic exercise and TENS, have been tried and failed; or are judged to be unsuitable or contraindicated. There is lack of high quality evidence to prove long term efficacy. Percutaneous electrical nerve stimulation (PENS) is similar in concept to transcutaneous electrical nerve stimulation (TENS) but differs in that needles are inserted to a depth of 1 to 4 cm either around or immediately adjacent to the nerve serving the painful area and then stimulated. The submitted documentation lacked any evidence of the injured worker having trialed and failed the use of a TENS unit. Additionally, there was no indication of the injured worker having failed any therapeutic exercise. Furthermore, the request as submitted did not indicate where the percutaneous nerve stimulator would be used on the injured worker. Given the above guidelines and that it is not recommended by the MTUS, the request is not medically necessary.