Case Number:	CM14-0173263		
Date Assigned:	10/24/2014	**Date of Injury:**	05/18/2014
Decision Date:	12/17/2014	**UR Denial Date:**	10/03/2014
Priority:	Standard	**Application Received:**	10/20/2014

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 Neurology, has a subspecialty in Neuromuscular Medicine and is licensed to practice in New Jersey. 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 patient is a 51-year-old woman who sustained a work-related injury on May 18, 2014. Subsequently, she developed chronic low back pain. Prior treatments included: medications, physical therapy and chiropractic therapy (without relief), back support, and modified work. MRI of the lumbar spine dated July 14, 2014 showed: - L5-S1: 5 mm disc protrusion associated with mild bilateral neural foraminal stenosis and encroachment upon the bilateral L5 nerve roots. Minimal central canal stenosis was also seen. Facet hypertrophy contributed to stenosis.- L4-5: 3 mm disc protrusion associated with minimal mild left neural foraminal stenosis. facet hypertrophy contributed to stenosis.- L2-3: 3 mm left paracentral/posteriolateral disc protrusion associated with minimal mild left neural foraminal stenosis. short pedicles, ligamentum flavum redundancy and facet hypertrophy contributed to stenosis.- L3-4: 2.5 mm left paracentral disc bulge associated with minimal left neural foraminal stenosis.- Fatty infiltration of the filum terminale.The EMG/NCS dated September 24, 2014 documented a normal electromyographic needle examination for the lower extremities and related lumbosacral paraspinous musculature. There was no evidence of lumbosacral radiculopathy, plexopathy, or peripheral nerve entrapment. According to a progress report dated October 3, 2014, the patient complained of low back pain with radicular pain down the right leg. She rated her pain as a 5/10. She stated that the therapy is helping and that her symptoms are decreasing.physical examination revealed tenderness in the lumbar spine from L3 through L5 and associated paraspinal muscles, right SI joint. There was positive Ptrick-Faber's test on the right. there was positive straight leg raise test on the right. The patient was diagnosed with lumbar spine disc bulge and lumbar spine radiculitis. The provider requested authorization for Right L4-L5 and L5-S1 transforaminal

IMR ISSUES, DECISIONS AND RATIONALES

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

Right L4-L5 and L5-S1 transforaminal epidural steroid injection: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309.

Decision rationale: According to MTUS guidelines, epidural steroid injection is optional for radicular pain to avoid surgery. It may offer short term benefit, however there is no signficant long term benefit or reduction for the need of surgery. Furthermore, the patient file does not document that the patient is candidate for surgery. In addition, there is no recent clinical and objective documentation of radiculopathy. The EMG of September 2014 documented no evidence of radiculopathy. MTUS guidelines does not recommend epidural injections for back pain without radiculopathy (309). Therefore, lumbar epidural steroid injection is not medically necessary.

Interferential unit 30 day trial for home use: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Interferential Current Stimulation Page(s): 118-119.

Decision rationale: According to MTUS guidelines, < Interferential Current Stimulation (ICS). Not recommended as an isolated intervention. There is no quality evidence of effectiveness except in conjunction with recommended treatments, including return to work, exercise and medications, and limited evidence of improvement on those recommended treatments alone. The randomized trials that have evaluated the effectiveness of this treatment have included studies for back pain, jaw pain, soft tissue shoulder pain, cervical neck pain and post-operative knee pain. (Van der Heijden, 1999)(Werner, 1999) (Hurley, 2001) (Hou, 2002) (Jarit, 2003) (Hurley, 2004) (CTAF, 2005)(Burch, 2008) The findings from these trials were either negative or non-interpretable for recommendation due to poor study design and/or methodologic issues.While not recommended as an isolated intervention, Patient selection criteria if Interferential stimulation is to be used anyway: Possibly appropriate for 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.).In this case, there is no clear evidence that the patient did not respond to conservative therapies, or have pain that limit her ability to perform physical

therapy. There is no clear documentation of failure of pharmacological treatments or TENS therapy. Therefore, the prescription of IF unit is not medically necessary.