

<b>Case Number:</b>	CM14-0179633		
<b>Date Assigned:</b>	11/03/2014	<b>Date of Injury:</b>	09/25/2013
<b>Decision Date:</b>	05/11/2015	<b>UR Denial Date:</b>	10/21/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/28/2014

### 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. 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, Arizona  
 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 53-year-old male who reported an injury on 09/25/2013, which occurred while he was working on an 8 foot ladder, lost his balance, and ended up straining the left arm and shoulder as he tried to hold on to some pipes hanging down from the ceiling. He ultimately let go and fell to the ground 8 feet below. Past treatment includes conservative management including 15 visits of physical therapy, cortisone injections, and various anti-inflammatory and analgesic medications, with wrist bracing. The records indicate that the injured worker was approved for a left shoulder arthroscopic subacromial decompression, joint bursectomy of the left shoulder, partial distal clavicle resection, and preoperative medical clearance on 02/05/2014. There was no documentation in the medical records that the injured worker was using an interferential unit. There were no recent diagnostic studies submitted for review. There are no relevant surgical histories. Current medications include Norco and Flexeril. The comprehensive pain management consultation report dating 09/03/2014 indicates the injured worker had continued complaints of pain in the lower back. There was indication that the injured worker had complaints of radiating pain to the right leg down to the calf with numbness and tingling sensations to the foot. Physical examination noted diffuse tenderness over the lumbar peritoneal musculature. There was moderate facet tenderness noted over the L3-5 level. Patrick's test was positive bilaterally, sacroiliac thrust test, and Yeoman's test were also positive bilaterally. Kemp's test was also positive bilaterally, with a bowstring sign positive on the right side at 50 degrees. Seated straight leg raise was noted to be positive on the right side at 40 degrees. Lumbar spine range of motion was noted to be 20 degrees of lateral bending to the right side,

with 20 degrees of lateral bending to the left side. Flexion was noted to be 60 degrees and extension was 10 degrees. Sensation was decreased as to pain, temperature, light touch, vibration and 2 point discrimination in the right L3-4 dermatomes.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

#### **Right L3-L4 transforaminal epidural steroid injection, QTY 1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of Epidural steroid injections Page(s): 46.

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

**Decision rationale:** California MTUS Guidelines indicate that the criteria for the use of epidural steroid injections include documentation of radiculopathy on physical examination and corroborated by imaging studies and/or electrodiagnostic testing. There were no imaging studies, or electrodiagnostic testing submitted for review that would indicate radiculopathy. Given the above, this request is not medically necessary.

#### **Right L4-L5 transforaminal epidural steroid injection, QTY 1: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of Epidural steroid injections Page(s): 46.

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

**Decision rationale:** California MTUS Guidelines indicate that the criteria for the use of epidural steroid injections include documentation of radiculopathy on physical examination and corroborated by imaging studies and/or electrodiagnostic testing. There were no imaging studies, or electrodiagnostic testing submitted for review that would indicate radiculopathy. Given the above, this request is not medically necessary.

#### **Replacement batteries for interferential unit QTY. 1: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Transcutaneous electrotherapy Page(s): 114, 118, and 120.

**Decision rationale:** The clinical documentation submitted for review shows no indication of the use of an interferential current stimulation, and no rationale to support its use. As such, this request is not medically necessary.

**Replacement electrodes for interferential unit:** 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 Transcutaneous electrotherapy Page(s): 114, 118, and 120.

**Decision rationale:** The clinical documentation submitted for review shows no indication of the use of an interferential current stimulation, and no rationale to support its use. As such, this request is not medically necessary.