

Case Number:	CM15-0004862		
Date Assigned:	01/16/2015	Date of Injury:	02/15/2006
Decision Date:	03/19/2015	UR Denial Date:	12/17/2014
Priority:	Standard	Application Received:	01/09/2015

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: California
 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 57 year old female, who sustained an industrial injury on February 15, 2006. She reported low back pain with intermittent radiation into the legs. The diagnoses have included lumbar spine musculoligamentous sprain/strain and cervical spine musculoligamentous sprain/strain. Treatment to date has included diagnostic studies, chiropractic sessions, acupuncture and medications. Currently, the injured worker complains of low back pain with increasing sciatic pain along with numbness and tingling. She noted radicular pain that increased with any flexing activity. Her chiropractic therapy and acupuncture treatment provided temporary relief but she still continued to experience her radicular symptoms. On December 17, 2014, Utilization Review non-certified a replacement of interferential unit, noting the California Chronic Pain Medical Treatment Guidelines. Utilization Review conditionally non-certified bilateral C4-5 and right C5-6 transfacet epidural steroid injections x2, noting the California Chronic Pain Medical Treatment Guidelines. On January 7, 2015, the injured worker submitted an application for Independent Medical Review for review of replacement of interferential unit and bilateral C4-5 and right C5-6 transfacet epidural steroid injections x2.

IMR ISSUES, DECISIONS AND RATIONALES

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

Replacement of interferential unit: 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 Interferential Current Stimulation, TENS Page(s): 114-121.

Decision rationale: According to the 12/17/14 Utilization Review letter, the replacement interferential unit requested on the 11/18/14 medical report was denied because it was already authorized on 11/03/14, and there was no findings indicating need for another interferential unit. The 11/18/14 medical report was not available for this review. The most recent report provided for this review is dated 3/13/14. MTUS Chronic Pain Medical Treatment Guidelines, TENS, pg114-121, for Interferential Current Stimulation patient selection criteria includes:- 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.). There is not enough information provided to determine if the patient currently meets the MTUS criteria for an IF unit. The most recent report provided is 8-months before the patient reportedly received authorization for the first IF replacement unit. There are no available reports to suggest that the replacement unit is not working, and there are no current reports that discuss the patient's substance abuse problems, or ineffectiveness of medications, or postoperative conditions. The records provided from 10/14/2013 through 3/13/2014 do not support necessity of the 2nd replacement interferential unit on 11/18/2014. Based on the limited information provided, the request for Replacement of interferential unit IS NOT medically necessary.

Left L3-L4 selective epidural catheterization: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ESI Page(s): 46-47.

Decision rationale: According to the 12/17/14 Utilization Review letter, the left L3/4 SNRB requested on the 11/18/14 medical report was denied because there was no exam findings identifying a specific dermatomal distribution of pain. The 11/18/14 medical report was not provided for this review. There are no MRI or electrodiagnostic reports provided for this review. The medical records provided for this review include 7 reports from 10/14/2013 through 3/13/2014. MTUS Chronic Pain Treatment Guidelines, section on Epidural steroid injections [ESIs] page 46 states these are recommended as an option for treatment of radicular pain [defined as pain in dermatomal distribution with corroborative findings of radiculopathy]. The MTUS Criteria for the use of Epidural steroid injections states: Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Based on the available reports, the patient does not meet the MTUS requirements for an epidural steroid injection. The 11/18/14 report corresponding to the

treatment request was not provided for this review. There are no MRI or electrodiagnostic studies or current physical examination findings provided. The request for Left L3-L4 selective epidural catheterization, IS NOT medically necessary.