MAXIMUS Federal Services

Case Number:	CM13-0007953		
Date Assigned:	03/03/2014	Date of Injury:	12/06/2012
Decision Date:	04/15/2014	UR Denial Date:	07/18/2013
Priority:	Standard	Application Received:	08/06/2013

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 Management and is licensed to practice in California. 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:

According to the records made available for review, this is a 45-year-old female with a 12/6/12 date of injury. At the time (7/8/13) of request for authorization for right L5-S1 selective transforaminal epidural steroid injection and physical therapy times eight (8), there is documentation of subjective (persistent back and right radiating leg symptoms that had been partially helped doing physical therapy) and objective (slight weakness with right EHL strength; and decreased sensation in the L5 distribution on the right side particularly in the upper thigh region and slightly in the lateral right calf) findings, imaging findings (MRI lumbar spine (4/24/13) report revealed slight desiccation of the intervertebral discs L4-L5 and L5-S1 with no significant narrowing spinal canal or intervertebral foramina), current diagnosis (right L5-S1 radiculopathy), and treatment to date (physical therapy, chiropractic treatment, and medications). Regarding right L5-S1 selective transforaminal epidural steroid injection, there is no documentation of imaging (MRI, CT, myelography, or CT myelography & x-ray) findings (nerve root compression OR moderate or greater central canal stenosis, lateral recess stenosis, or neural foraminal stenosis) at the requested level and failure of additional conservative treatment (physical modalities). Regarding physical therapy times eight (8), the number of previous physical therapy sessions cannot be determined. In addition, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services as a result of physical therapy provided to date.

IMR ISSUES, DECISIONS AND RATIONALES

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

RIGHT L5-S1 SELECTIVE TRANSFORAMINAL EPIDURAL STEROID INJECTION: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG), INTEGRATED TREATMENT GUIDELINES

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) LOW BACK, EPIDURAL STEROID INJECTIONS (ESIS)

Decision rationale: MTUS reference to ACOEM Guidelines identifies documentations of objective radiculopathy in an effort to avoid surgery, as criteria necessary to support the medical necessity of epidural steroid injections. ODG identifies documentation of subjective (pain, numbness, or tingling in a correlating nerve root distribution) and objective (sensory changes, motor changes, or reflex changes in a correlating nerve root distribution) radicular findings in each of the requested nerve root distributions, imaging (MRI, CT, myelography, or CT myelography & x-ray) findings (nerve root compression OR moderate or greater central canal stenosis, lateral recess stenosis, or neural foraminal stenosis) at each of the requested levels, and failure of conservative treatment (activity modification, medications, and physical modalities); as criteria necessary to support the medical necessity of lumbar transforaminal epidural steroid injection. Within the medical information available for review, there is documentation of a diagnosis of right L5-S1 radiculopathy. In addition, there is documentation of subjective (pain) and objective (sensory changes and motor changes) radicular findings in the requested nerve root distribution, and failure of conservative treatment (activity modification and medications). However, given documentation of imaging findings (MRI lumbar spine identifying slight desiccation of the intervertebral discs L4-L5 and L5-S1 with no significant narrowing spinal canal or intervertebral foramina), there is no documentation of imaging (MRI, CT, myelography, or CT myelography & x-ray) findings (nerve root compression OR moderate or greater central canal stenosis, lateral recess stenosis, or neural foraminal stenosis) at the requested level. In addition, given documentation of an associated request for physical therapy, there is no documentation of failure of additional conservative treatment (physical modalities). Therefore, based on guidelines and a review of the evidence, the request for right L5-S1 selective transforaminal epidural steroid injection is not medically necessary.

PHYSICAL THERAPY TIMES EIGHT (8): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL MEDICINE. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, PHYSICAL MEDICINE,

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL MEDICINE Page(s): 98. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) LOW BACK, PHYSICAL THERAPY

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines support a brief course of physical medicine for patients with chronic pain not to exceed 10 visits over 4-8 weeks with allowance for fading of treatment frequency, with transition to an active self-directed program of independent home physical medicine/therapeutic exercise. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services (objective improvement with previous treatment).ODG recommends a limited course of physical therapy for patients with a diagnosis of lumbar radiculopathy not to exceed 12 visits over 8 weeks. ODG also notes patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy) and when treatment requests exceeds guideline recommendations, the physician must provide a statement of exceptional factors to justify going outside of guideline parameters. Within the medical information available for review, there is documentation of a diagnosis of right L5-S1 radiculopathy. In addition, there is documentation of previous physical therapy. Furthermore, given documentation of subjective (persistent back and right radiating leg symptoms that had been partially helped doing physical therapy) and objective (slight weakness with right EHL strength; and decreased sensation in the L5 distribution on the right side particularly in the upper thigh region and slightly in the lateral right calf) findings, there is documentation of functional deficits and functional goals. However, there is no documentation of the number of previous physical therapy treatments, and if the number of treatments have exceeded guidelines, a statement of exceptional factors to justify going outside of guideline parameters. In addition, despite documentation that symptoms had partially helped doing physical therapy, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services as a result of physical therapy provided to date. Therefore, based on guidelines and a review of the evidence, the request for physical therapy times eight (8) is not medically necessary.