

Case Number:	CM13-0014838		
Date Assigned:	12/04/2013	Date of Injury:	10/22/2012
Decision Date:	01/31/2014	UR Denial Date:	08/12/2013
Priority:	Standard	Application Received:	08/22/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine & Rehabilitation and is licensed to practice in Oklahoma and Texas. 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 physician 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.

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 59-year-old male who reported an injury on 10/19/2012. The patient is currently diagnosed with lumbar radiculopathy, spinal lumbar degenerative disc disease, low back pain, and left hip pain. The patient was recently seen by [REDACTED] on 07/24/2013. The patient reported ongoing lower back and left hip pain. Physical examination revealed positive straight leg raising on the left, tenderness over the coccyx to the left of the center of the spine, tenderness over the left sacroiliac (SI) joint, tenderness over the groin, trochanter, positive Gaenslen's and Faber testing, 5/5 motor strength in bilateral lower extremities, and decreased sensation over the lateral foot, medial foot, lateral calf, lateral thigh on the left. Treatment recommendations included physical therapy x12 sessions as well as an SI joint injection and a transforaminal lumbar epidural steroid injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy two (2) times a week for six (6) weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-99. Decision based on Non-MTUS Citation ODG, Preface, Physical Therapy Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-99.

Decision rationale: The Chronic Pain Guidelines indicate that active therapy is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. The guidelines allow for a fading of treatment frequency plus active self-directed home physical medicine. Treatment for radiculitis includes 8 to 10 visits over 4 weeks. The current request for physical therapy two (2) times per week for six (6) weeks exceeds guideline recommendations for a total duration of treatment. As such, the request is non-certified.

Transforaminal lumbar epidural steroid injection, L4-L5 and L5-S1 on the left side:
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 Chronic Pain Guidelines indicate that epidural steroid injections are recommended as a possible option for the treatment of radicular pain, with use in conjunction with other rehab efforts. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Patients should prove initially unresponsive to conservative treatment. As per the clinical notes submitted, the patient underwent an MRI of the lumbar spine on 10/21/2012 which indicated mild disc desiccation at L4-5 and L5-S1 with mild hypertrophic spur formation, mild to moderate left paracentral disc protrusion mildly effacing and displacing to the left S1 nerve root at L5-S1. While it is noted that the patient has been previously treated with narcotic medication, there is no evidence of a failure to respond to recent conservative treatment including exercises, physical methods, NSAIDS, and muscle relaxants. There is also no evidence of this patient's active participation in a home exercise program to be used in conjunction with injection therapy. Based on the clinical information received, the patient does not current meet criteria for an epidural steroid injection.

Left sacroiliac (SI) joint 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), Hip and Pelvis Chapter, Sacroiliac joint blocks.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Hip and Pelvis Chapter, Sacroiliac joint blocks.

Decision rationale: The MTUS/ACOEM Guidelines indicate that invasive techniques such as local injections are of questionable merit. The Official Disability Guidelines indicate that the history and physical should suggest a diagnosis prior to sacroiliac joint blocks. The patient should have tried and failed at least 4 to 6 weeks of aggressive conservative therapy including physical therapy, home exercise, and medication management. Based on the clinical information

received, the patient does not currently meet the criteria for a sacroiliac joint block, as there is no documentation of a failure to respond to at least 4 to 6 weeks of aggressive conservative therapy including physical therapy and home exercise. Therefore, the request is non-certified.