MAXIMUS Federal Services

Case Number:	CM13-0034599		
Date Assigned:	12/11/2013	Date of Injury:	10/19/2012
Decision Date:	11/26/2014	UR Denial Date:	10/03/2013
Priority:	Standard	Application Received:	10/15/2013

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 Physical Medicine and Rehabilitation, has a subspecialty in Neuromuscular Medicine and is licensed to practice in Maryland. 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 60 year old male who had a work injury dated 10/19/12. The diagnoses include lumbar radiculopathy, lumbar degenerative disc disease, low back pain; and left hip pain. Under consideration are requests for physical therapy two times a week for 6 weeks (12); Transforaminal lumbar epidural injection L5-S1 and S1-S2 left side; and referral to a chiropractor for 12 visits. A 10/2112 lumbar MRI states that there is l. Mild central canal stenosis most apparent at the L3-L4 and L4-L5 levels. 2. Mild diffuse degenerative changes. 3. Mild to moderate left paracentral disc protrusion at L5-S1 mildly effacing and displacing the S1 nerve root. A 9/25/13 progress note states that the patient's pain leve1 has decreased since his last visit. His pain is a 4-5/10. The patient states that PT is helpful. He denies any change in pain location or side effects. He wishes to discuss possibility of epidural steroid injections with PCP before undergoing as he is concerned regarding kidney due to diabetes. Motor of the EHL is 5/5 on the right and 5-/5 on the left. Ankle dorsiflexion, plantarflexion, knee dorsi and plantar flexion and hip flexors bilaterally are 5/5. On sensory examination, the light touch sensation is decreased over the lateral foot, medial foot, lateral calf, lateral thigh, decreased over L4, L5 dermatomal pattern on the left. Deep tendon reflexes are equal on both sides. Ankle clonus and babinski is negative. Straight leg raising test is positive on the left side. The treatment plan includes the above requests under consideration.

IMR ISSUES, DECISIONS AND RATIONALES

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

PHYSICAL THERAPY 2 TIMES A WEEK FOR 6 WEEKS (12): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL MEDICINE Page(s): 98-99.

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

Decision rationale: Physical therapy two times a week for 6 weeks (12) is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines recommend up to 10 visits for this condition. The request exceeds this number. Additionally, the patient has had prior PT and should be well versed in a home exercise program which the documentation reports he is going. It is unclear from the documentation submitted why the patient needs 12 more supervised therapy visits. The request for physical therapy two times a week for 6 weeks (12) is not medically necessary.

TRANSFORAMINAL LUMBAR EPIDURAL INJECTION L5-S1 AND S1-S2 LEFT SIDE: 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 Epidural steroid injections ESIs Page(s): 46.

Decision rationale: Transforaminal lumbar epidural injection L5-S1 and S1-S2 left side is not medically necessary per the MTUS Guidelines.The guidelines state that) radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. The documentation does not indicate objective findings on physical exam in the S1-S2 dermatomes or myotomes therefore the request for transforaminal lumbar epidural injection L5-S1 and S1-S2 left side is not medically necessary.

REFERRAL TO A CHIROPRACTOR FOR 12 VISITS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MANUAL THERAPY & MANIPULATION Page(s): 58-60.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Manual therapy & manipulation Page(s): 58-60.

Decision rationale: Referral to a chiropractor for 12 visits is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. It is unclear whether this patient has had chiropractic care in the past given a date of injury in 2012. The guidelines state that trial of 6 visits over 2 weeks, withevidence of objective functional improvement, total of up to 18 visits over 6-8 weeks. Maintenance care is not medically necessary. For flare up there is a need to reevaluate treatment success, if return to work is achieved then 1-2 visits every 4-6 months. The

request exceeds the recommendation for a trial of 6 visits if the patient has not had chiropractic care therefore the request for Referral to a chiropractor for 12 visits is not medically necessary.