

Case Number:	CM13-0059685		
Date Assigned:	12/30/2013	Date of Injury:	12/27/2012
Decision Date:	04/04/2014	UR Denial Date:	11/22/2013
Priority:	Standard	Application Received:	12/02/2013

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 Internal Medicine, has a subspecialty in Pulmonary diseases, 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 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. 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 54-year-old who reported an injury on 12/27/2012. The mechanism of injury was a fall. The note dated 11/01/2013 indicated the patient had complaints of upper, mid, and low back pain, bilateral shoulder pain, right forearm pain, bilateral hip and knee pain, left heel pain with tingling in the lower extremities, and blurry vision. Upon examination of the lumbar spine, there was muscle spasm noted. The right-sided erector spinalis trigger points were positive. There was tenderness to palpation on the right of the lumbar spine "paravertebra". The straight leg raise was positive on the right at 40 degrees of elevation. There was general muscle weakness secondary to pain on the right side of the low back. The heel walk was performed with difficulty. Flexion and extension maneuvers demonstrated decreased strength of 4/5 with limited range of motion. Flexion caused moderate pain and extension caused mild pain. There was good dorsiflexion and plantar flexion power noted. It was noted the treatment plan included Voltaren 75 mg twice daily, Norflex 100 mg twice daily as needed, and Ortho-Nesic gel. It was noted that an epidural steroid facet injection of the lumbar spine at L3-5 x2 with post injection physical therapy 3 times a week for 3 weeks was recommended. The MRI of the lumbar spine dated 02/01/2013 revealed (1) lumbar spondylosis L2-3 through L5-S1 discs; (2) at L5-S1, a 4 mm broad-based posterior disc protrusion; (3) at L4-5, a 3 mm posterior disc protrusion; (4) at L3-4, a 3 mm posterior osteophyte disc complex, more prominent laterally.

IMR ISSUES, DECISIONS AND RATIONALES

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

Two lumbar ESIs (Epidural Steroid Injections) at L3-L5: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

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

Decision rationale: The Physician Reviewer's decision rationale: The request for lumbar ESI at L3-5 is non-certified. The Chronic Pain Medical Treatment Guidelines state that epidural steroid injections are recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution without corroborative findings of radiculopathy). The criteria for the use of steroid epidural injections are radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing, and the patient must initially be unresponsive to conservative treatment (exercise, physical methods, NSAIDs [non-steroidal anti-inflammatory drugs], and muscle relaxants). The records provided for review failed to include documentation of objective findings such as muscle weakness or loss of sensation in the lower extremities to support radiculopathy. In addition, there is lack of documentation showing the patient was unresponsive to conservative treatment, including exercise, physical methods, NSAIDs, and muscle relaxants. As such, the request for lumbar ESI at L3-5 is not supported. The request for two lumbar ESIs at L3-L5 is not medically necessary.

Post-operative physical therapy to the lumbar back, three times per week for three weeks:
Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary or appropriate.