

Case Number:	CM13-0062761		
Date Assigned:	01/03/2014	Date of Injury:	07/02/1986
Decision Date:	05/12/2014	UR Denial Date:	11/26/2013
Priority:	Standard	Application Received:	12/09/2013

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 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:

This is a female patient with the date of injury of July 2, 1986. A utilization review determination dated November 26, 2013 recommends non-certification of aquatic therapy on a daily basis, non-certification of lumbar epidural steroid injection, non-certification of deep breathing type meditation, and follow-up in 4 weeks. Non-certification of aquatic therapy is recommended as the patient has a normal motor exam and is capable of ambulating and weight-bearing and has participated in land-based therapy. A progress report dated November 11, 2013 identify subjective complaints indicating that the patient has gotten over 50% improvement from trigger point injections. The note indicates that the medication improves the patient's pain significantly. She has been able to ambulate with the aid of a cane. Objective examination findings identify slightly restricted thoracic and lumbar range of motion, unable to perform heel gait with either foot or leg, and decreased sensation in the lateral aspect of the left calf area. Diagnoses include chronic myofascial pain syndrome, thoracolumbar spine, and failed back syndrome pain, numbness, and weakness of bilateral lower extremities. Treatment plan recommends epidural steroid injection and continued medications, a home muscle stretching exercise, aquatic therapy exercises on a 2 daily basis, deep breathing type meditation, and follow-up.

IMR ISSUES, DECISIONS AND RATIONALES

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

A LUMBAR EPIDURAL STEROID INJECTION L4-5 UNDER FLUOROSCOPY:

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 (ESI) Section Page(s): 46.

Decision rationale: Regarding the request for lumbar epidural injection, Chronic Pain Medical Treatment Guidelines state that epidural injections are recommended as an option for treatment of radicular pain, defined as pain in dermatomal distribution with corroborative findings of radiculopathy. Regarding repeat epidural injections, guidelines state that repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than four blocks per region per year. Within the documentation available for review, there are no recent objective examination findings supporting a diagnosis of radiculopathy. Additionally, there are no imaging or electrodiagnostic studies corroborating the diagnosis of radiculopathy. Additionally, it is unclear whether the patient has previously undergone epidural injections, and if so, what the outcome of those injections might have been. The request for a lumbar steroid injection at L4-L5 under fluoroscopy is not medically necessary or appropriate.

AQUATIC THERAPY ON A DAILY BASIS: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298, Chronic Pain Treatment Guidelines Page(s): 22, and 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Physical Therapy Section.

Decision rationale: Regarding the request for aquatic therapy, Chronic Pain Treatment Guidelines state that aquatic therapy is recommended as an optional form of exercise therapy where available as an alternative to land-based physical therapy. They go on to state that it is specifically recommended whenever reduced weight bearing is desirable, for example extreme obesity. Guidelines go on to state that for the recommendation on the number of supervised visits, see physical therapy guidelines. Within the documentation available for review, there is no documentation indicating why the patient would require therapy in a reduced weight-bearing environment. Furthermore, there is no indication as to how many physical therapy sessions the patient has undergone and what specific objective functional improvement has been obtained with the therapy sessions already provided. Finally, there is no statement indicating whether the patient is performing a home exercise program on a regular basis, and whether or not that home exercise program has been modified if it has been determined to be ineffective. The request for aquatic therapy on a daily basis is not medically necessary or appropriate.

