

Case Number:	CM13-0065435		
Date Assigned:	01/03/2014	Date of Injury:	07/25/1998
Decision Date:	04/15/2014	UR Denial Date:	12/02/2013
Priority:	Standard	Application Received:	12/13/2013

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 Pediatric Rehabilitation Medicine and is licensed to practice in 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 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 67 year old female that reported an injury on 07/25/1988. The mechanism of injury was not included in the medical records and is noted to be over twenty five years old. Surgeries noted as 08/20/2013 status post anterior cervical discectomy and fusion. Diagnostic studies include a cervical spine MRI without contrast on 05/09/2013 which revealed fusion of C5-C6 vertebral bodies with anterior fusion hardware at C6-C7 with a prosthetic disc space and the C6-C7 disc is not fused. The clinical note dated 10/29/2013 states that the patient is status post cervical surgery and that the patient has improved significantly and that the patient reported some radiating pain in the bilateral lower extremities and upper extremities. The patient had good motor strength with some pain across her neck. Examination revealed no focal deficits, tenderness to palpation over the lumbar spine, positive sciatic notch pain, decreased cadence and stride length, an antalgic gait and positive straight leg raise at 90 degrees. A bilateral caudal epidural steroid injection at L4-L5, bilateral facet block injections at L4-L5 followed by physical therapy was recommended.

IMR ISSUES, DECISIONS AND RATIONALES

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

(B) lumbar caudal epidural injection L4-5: 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: CA MTUS states epidural steroid injections are supported for patients with documented objective radiculopathy that is corroborated with imaging and/or electrodiagnostic studies and have failed conservative care. The examination provided failed to document the presence of significant radiculopathy as there were no focal deficits noted and no sensory or muscle deficits on examination to meet guideline criteria. There is a lack of documentation provided supporting the patient has had a trial of conservative care for the lumbar spine that has not provided benefit. Therefore, the request is non-certified.

(B) Lumbar caudal facet block injection at L4-5 with fluoroscopy: 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): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Facet Injections.

Decision rationale: The CA MTUS/ACOEM guidelines state invasive techniques (e.g., local injections and facet joint injections of cortisone and lidocaine) are of questionable merit. Official Disability Guidelines state facet injections are limited to patient with low-back pain that is non-radicular and at no more than two levels bilaterally. It is recommended for facet joint signs and symptoms to include a negative straight leg raise and with documentation of failure of conservative care. The patient is noted to have a positive straight leg raise and there is a lack of documentation of failure of conservative care to meet guideline criteria. Therefore the request is non-certified.

PHYSICAL THERAPY (PT) 2x4: Upheld

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

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

Decision rationale: The CA MTUS states would support 9-10 sessions of physical therapy for myalgia and myositis and 8-10 sessions for neuralgia. The request was submitted failed to indicate the location of the body the therapy was being requested for. The examination provided indicated there was a lack of focal motor deficits of the lower extremities and that range of motion was improved; however, failed to indicate the area of the body the range of motion was referencing and failed to provide objective measurements the patient's range of motion indicating significant deficits to support formal supervised therapy. Also, the clinical information provided indicated the recommended therapy would be performed after the recommended epidural steroid

injection and facet injection. However, as the injections have not been certified, the necessity of post injection therapy is not supported. Therefore, the request is non-certified