

Case Number:	CM14-0118469		
Date Assigned:	08/06/2014	Date of Injury:	05/03/2011
Decision Date:	10/01/2014	UR Denial Date:	07/17/2014
Priority:	Standard	Application Received:	07/28/2014

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 Family Medicine 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 55-year-old female who reported an industrial injury to the back on 5/3/2011, over three years ago, attributed to the performance of her usual and customary job tasks. The patient has been treated with PT; medications; lumbar brace; chiropractic sessions; acupuncture; TENS unit; activity modifications, and a prior lumbar ESis. A MRI the lumbar spine was dated 4/4/2014 and demonstrated evidence of mild multilevel degenerative change; no significant interval change; L5-S1 with mild right paracentral/foraminal bulging; mild narrowing of the right lateral recess without significant displacement of the right descending S1 nerve root; normal central canal and inter-vertebral neural foraminal. The patient complained of persistent neck pain. The patient reportedly received no relief from three separate lumbar epidural injections. The objective findings on examination documented evidence of diminished right ankle reflex; weakness bilateral knee extension; decreased sensation to the right lateral foot compared to the left. The EMG/NCS on 10/10/2011 documented no evidence of lumbosacral radiculopathy. The treatment plan included a right L5-S1 transforaminal epidural steroid injection under fluoroscopy and eight sessions of core strengthening, conditioning, HEP, abdominal strengthening, postural exercises, ergo training, and biomechanical reeducation. The patient was modified to certify six sessions of physical therapy to learn a self-directed home exercise program.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right L5-S1 transforaminal epidural steroid injection under fluoroscopy: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300,Chronic Pain Treatment Guidelines Guidelines Epidural Steroid injections Page(s): 46.

Decision rationale: The criteria required by the CA MTUS for the provision of a selective nerve root block or transforaminal lumbar ESI directed to right L5-S1 was not documented by the requesting provider. The patient does not meet the CA MTUS criteria for a lumbar ESI under fluoroscopic guidance. The use of lumbar spine ESIs is recommended for the treatment of acute or subacute radicular pain in order to avoid surgical intervention. The patient is not noted to have objective findings on examination consistent with a nerve impingement radiculopathy. The patient is noted to have a MRI of the lumbar spine that demonstrates disc bulges that L5-S1, however, there is no objective evidence of a nerve impingement radiculopathy. The performed Electrodiagnostic studies of the bilateral lower extremities do not demonstrate evidence of any nerve impingement radiculopathy. There are no currently documented objective findings on examination that are corroborated by the NCS study or MRI evidence. The reported radiculopathy was not corroborated by imaging studies or physical examination. There is no impending surgical intervention. The patient is being treated for chronic low back pain attributed to an annular tear and lumbar spine DDD. The patient is documented to have had a rehabilitation effort along with physical therapy; however, the last office visit documented no neurological deficits along a dermatomal distribution to the bilateral lower extremities and noted that the patient was improving with physical therapy and exercise. There is no demonstrated medical necessity for the provision of transforaminal lumbar ESI at right L5-S1. The patient has received 3+ prior lumbar spine ESI's with no demonstrated sustained functional improvement. The request for an additional lumbar ESI represents maintenance care. The stated diagnoses and clinical findings do not meet the criteria recommended by evidence-based guidelines for the use of a lumbar transforaminal ESI by pain management. The CA MTUS requires that "Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing." The ACOEM Guidelines updated Back Chapter revised 8/08/08 does not recommend the use of lumbar ESIs for chronic lower back pain. The Official Disability Guidelines recommend that ESIs are utilized only in defined radiculopathies and a maximum of two lumbar diagnostic ESIs and a limited number of therapeutic lumbar ESIs are recommended in order for the patient to take advantage of the window of relief to establish an appropriate self-directed home exercise program for conditioning and strengthening. The criteria for a second diagnostic ESI is that the claimant obtain at least 50% relief from the prior appropriately placed ESI. The therapeutic lumbar ESIs are only recommended, "If the patient obtains 50-70% pain relief for at least 6-8 weeks." Additional blocks may be required; however, the consensus recommendation is for no more than four (4) blocks per region per year. The indications for repeat blocks include "acute exacerbations of pain or new onset of symptoms." Lumbar ESIs should be performed at no more than two levels at a session. Although epidural injection of steroids may afford short-term improvement in the pain and sensory deficits in patients with radiculopathy due to herniated nucleus pulposus, this treatment, per the guidelines, seems to offer no significant long-term functional benefit, and the number of injections should be limited to two, and only as an option for short term relief of radicular pain after failure of conservative treatment and as a means of avoiding surgery and facilitating return to activity. The patient is being treated for a subjective

radiculitis with reported chronic low back without MRI or physical examination evidence of a nerve impingement radiculopathy. There is no demonstrated medical necessity for a lumbar spine ESI for the reported chronic pain issues. The request for a lumbar spine TFLESI L5-S1 is not medically necessary.

8 Sessions of core strengthening, conditioning, HEP, abdominal strengthening, postural exercises, ergo training and biomechanical re-education: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 299-300, Chronic Pain Treatment Guidelines (ODG) neck and upper back chapter-PT; back chapter-PT.

Decision rationale: The request is for authorization of eight (8) additional sessions of PT to the back three (3) years after the DOI exceeds the number of sessions of PT recommended by the CA MTUS and the time period recommended for rehabilitation. The evaluation of the patient documented no objective findings on examination to support the medical necessity of physical therapy three (3) years after the cited DOI with no documented weakness or muscle atrophy as opposed to a self-directed HEP. There are no objective findings to support the medical necessity of 8 sessions of physical therapy for the rehabilitation of the patient over the number recommended by evidence-based guidelines. The patient is documented with no signs of weakness, no significant reduction of ROM, or muscle atrophy. There is no demonstrated medical necessity for the prescribed PT to the back 3 years after the DOI. The patient is not documented to be in HEP. There is no objective evidence provided by the provider to support the medical necessity of the requested eight additional sessions of PT over a self-directed home exercise program. The CA MTUS recommends ten (10) sessions of physical therapy over 8 weeks for the lumbar spine rehabilitation subsequent to lumbar strain/sprain and lumbar spine DDD with integration into HEP. The provider did not provide any current objective findings to support the medical necessity of additional PT beyond the number recommended by evidence-based guidelines. The requested additional 10 sessions of PT is not medically necessary.

