

Case Number:	CM14-0177380		
Date Assigned:	10/30/2014	Date of Injury:	06/02/2006
Decision Date:	12/08/2014	UR Denial Date:	10/10/2014
Priority:	Standard	Application Received:	10/27/2014

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain 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 male patient with a date of injury of June 2, 2006. A utilization review determination dated October 10, 2014 recommends a non-certification of an outpatient caudal epidural steroid injection with anesthesia and fluoroscopy, outpatient physical therapy 2 times a week for 6 weeks for the back, and lab work, EKG, and chest x-ray. A progress note dated September 29, 2014 identifies subjective complaints of the patient's most recent series of epidural injections were in March 2014, the patient is awaiting approval of physical therapy, and the patient needs facet blocks for the pain on extension. The patient had improvement of the back and radicular pain after the epidural injections but the pain on extension remains. He has less radicular pain, but it is still there. The patient needs stronger pain medications. Physical examination identifies low back muscle spasm, lumbar spine flexion to 40 without pain, bilateral leg raise to 50 without pain, and pain on extension of the lumbar spine to 5 with pain radiating to the low back and sacroiliac region. The diagnoses include lumbar discogenic syndrome, bilateral knee pain, muscle spasm, vitamin D deficiency, and lumbar facet arthropathy. The treatment plan recommends Norco 10/325, Butrans patch 10 per hour, vitamin D 50,000 IU, Cozaar 50 mg, diagnostic lumbar facet blocks one at a time that L4-S1, physical therapy, and a caudal epidural steroid injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient Caudal Epidural Steroid Injection with Anesthesia and Fluoroscopy: 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 of 127..

Decision rationale: Regarding the request for an outpatient caudal epidural steroid injection with anesthesia and fluroscopy, 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, and failure of conservative treatment. Guidelines recommend that no more than one interlaminar level, or to transforaminal levels, should be injected at one session. 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 4 blocks per region per year. Within the documentation available for review, the requesting physician has indicated that the patient had over 50% improvement with the previous epidural steroid injection. Unfortunately, there is no documentation of functional improvement or reduction in medication use as a result of that injection. Furthermore, there are no imaging or electrodiagnostic studies confirming a diagnosis of radiculopathy. Also, there are no objective findings to confirm a diagnosis of radiculopathy. As such, the request Outpatient Caudal Epidural Steroid Injection with Anesthesia and Fluroscopy is not medically necessary.

Outpatient Physical Therapy two (2) times a week for six (6) weeks for the Back: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298,Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 98 of 127. Decision based on Non-MTUS Citation Non-MTUS Official Disability Guidelines (ODG), Low Back Chapter, Physical Therapy

Decision rationale: Regarding the request for outpatient physical therapy 2 times a week for 6 weeks for the back, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, there is no indication of any specific objective treatment goals and no statement indicating why an independent program of home exercise would be insufficient to address any objective deficits. Furthermore, the request exceeds the amount of trial sessions of PT recommended by the CA MTUS. In the absence of such documentation, the request for Outpatient Physical Therapy 2 times a week for 6 weeks for the back is not medically necessary.

Lab work, EKG, AND chest X-ray: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Non-MTUS Official Disability Guidelines (ODG), Low Back Chapter, Preoperative lab testing and on <http://www.aafp.org/afp/2000/0201/p884.html>; Complete Blood Count (<http://labtestsonline.org/understanding/analytes/cbc/tab/test>); Comprehensive Metabolic Panel (<http://labtestsonline.org/understanding/analytes/cmp/tab/test>).

Decision rationale: Regarding the request for lab work, EKG, and chest X-ray, California MTUS and ODG do not address the issue of CBC or CMP testing. A CMP is ordered as a broad screening tool to evaluate organ function and check for conditions such as diabetes, liver disease, and kidney disease. The CMP may also be ordered to monitor known conditions, such as hypertension, and to monitor people taking specific medications for any kidney- or liver-related side effects. A CBC is ordered to evaluate various conditions, such as anemia, infection, inflammation, bleeding disorders, leukemia, etc. California MTUS and ODG do not address the issue of EKG. The AAFP supports ambulatory ECG for various indications including: for the evaluation of symptoms of cardiac arrhythmias; for risk assessment in patients who have sustained a myocardial infarction, have congestive heart failure (CHF) or have hypertrophic cardiomyopathy; for the evaluation of antiarrhythmic therapy, or pacemaker or implantable cardioverter-defibrillator function; and for the evaluation of possible myocardial ischemia. Within the documentation available for review, there is no clear indication for lab testing, EKG, or chest X-ray. In light of the above issues, the request Lab work, EKG, and chest X-ray is not medically necessary.