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| Case Number: | CM14-0186935 | | |
| Date Assigned: | 11/17/2014 | Date of Injury: | 10/25/2013 |
| Decision Date: | 01/05/2015 | UR Denial Date: | 10/20/2014 |
| Priority: | Standard | Application Received: | 11/10/2014 |

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 Emergency 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:

The injured worker is a 61-year-old female who reported an injury on 10/25/2013. The mechanism of injury was not specified. Her diagnosis included lumbar radiculopathy, lumbar sprain displaced without radiculopathy, lumbar spine stenosis, internal derangement of the right shoulder, rotator cuff syndrome and sprain/strain of the right shoulder; internal derangement and knee sprain/strain to bilateral knees. Her past treatments, surgeries or diagnostics were not included in the documentation. Her complaints, on 09/25/2014, were pain to the lumbar pain with a VAS rating of 7/10. She described these pains as intermittent and achy. She also had complaints of constant achy pain to both knees with a VAS score of 7/10 to 8/10. Upon physical examination, it was indicated that the lumbar spine range of motion was flexion 40/60 degrees, extension 20/25 degrees, right rotation 20/30 degrees, left rotation 20/30 degrees, and left and right lateral bends at 15/25 degrees. The clinical note also indicated the range of motion to the bilateral knees was flexion 120/130 degrees and extension 110/120 degrees. An anterior and posterior drawer test were positive to both knees. Medications included Xanax, Naproxen, Prilosec, tramadol HCL, gabapentin 10%/amitriptyline 10%/bupivacaine 15% cream, flurbiprofen 20%/baclofen 10%/dextromethorphan 2% cream, and Terocin patches. The treatment plan included an epidural steroid injection of the lumbar spine L4-5, physical therapy, and CMT therapy for 12 sessions to increase strength, range of motion, and to decrease pain. The Request for Authorization form was not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar ESI at L4-5 levels: 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 Page(s): 46.

Decision rationale: The decision for lumbar epidural steroid injection at L4-5 levels is not medically necessary. The California Medical Treatment Utilization Schedule Guidelines recommend epidural steroid injections as an option for treatment of radicular pain with corroborated findings of radiculopathy, and must be documented by physical examination, imaging studies, and/or electrodiagnostic testing. The clinical notes lack evidence of objective findings of radiculopathy including numbness or decreased sensation in a specific dermatomal pattern, decreased reflexes, or loss of strength; while the injured worker did have a positive bilateral straight leg raise at 30 degrees, there were no diagnostic studies to include an MRI, or the injured worker's unresponsiveness to conservative treatment to include exercise, physical methods, and efficacy of medications with quantifiable values. In addition the request did not indicate the use of fluoroscopy for guidance in the request. Therefore, the request is not medically necessary.

PT/CMT 2 x 6 for bilateral knees: 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 request for PT/CMT 2 x 6 for bilateral knees is not medically necessary. The California Medical Treatment Utilization Schedule states that physical medicine is to allow for fading treatments, plus an active self-directed home exercise program. The injured worker had a positive anterior and posterior drawer test; however, no evidence was submitted of an objective assessment of the injured worker's functional status, previous physical therapy findings, or a home based exercise program that would provide information on functional improvement. As such, the request for PT/CMT 2 x 6 for bilateral knees is not medically necessary.