

Case Number:	CM15-0002518		
Date Assigned:	01/13/2015	Date of Injury:	12/18/2013
Decision Date:	03/16/2015	UR Denial Date:	12/18/2014
Priority:	Standard	Application Received:	01/06/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Texas, Illinois

Certification(s)/Specialty: Preventive Medicine, Occupational Medicine

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 43 year old male, who sustained a work related injury on 12/18/13. The diagnoses have included mechanical back pain with protrusion of L4-L5 disc and a herniated nucleus pulposus. Treatments to date have included MRI lumbar spine, Voltaren gel, Flexeril, physical therapy and topical creams. The injured worker complains of constant, chronic low back pain. He has pain that radiates down right leg. He rates the pain a 4-5/10. He has limited range of motion of the lumbar spine, tenderness to palpation of lower back, the straight leg raise was up to 80 degrees with pain. On 1/6/15, Utilization Review non-certified a request for physical therapy 8 total visits, 2 times a week for 4 weeks. The California MTUS, Chronic Pain Treatment Guidelines, were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

High volume epidural steroid injection at L4-L5: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46.

Decision rationale: The injured worker sustained a work related injury on 12/18/13. The medical records provided indicate the diagnosis of mechanical back pain with protrusion of L4-L5 disc and a herniated nucleus pulposus. Treatments to date have included MRI lumbar spine, Voltaren gel, Flexeril, physical therapy and topical creams. The MRI of Lumbar dated 01/28/14 was unremarkable except for straightening and disc desiccation, there was no evidence of herniated disc or radiculopathy. The medical records provided for review do not indicate a medical necessity for High volume epidural steroid injection at L4-L5. The MTUS recommends Epidural steroid injection as an option in an individual with radicular pain in physical examination corroborated with imaging and or nerve studies. However, though the pain was radicular, the straight leg raise was up to 80 degrees (positive straight leg raise is between 30-70 degrees through the back of down below the knees in a radicular pattern); the MRI was negative for radiculopathy.

Physical therapy 2 x 4: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection; Physical Medicine Page(s): 46; 98-99.

Decision rationale: The injured worker sustained a work related injury on 12/18/13. The medical records provided indicate the diagnosis of mechanical back pain with protrusion of L4-L5 disc and a herniated nucleus pulposus. Treatments to date have included MRI lumbar spine, Voltaren gel, Flexeril, physical therapy and topical creams. The MRI of Lumbar dated 01/28/14 was unremarkable except for straightening and disc desiccation; there was no evidence of herniated disc or radiculopathy. The medical records provided for review do not indicate a medical necessity for Physical therapy 2 x 4. The injured worker is already receiving physical therapy, but this request is for additional Physical therapy to be coupled to high volume epidural steroid injection at L4-L5. The request is not medically necessary and appropriate since it has already been determined that the request for epidural steroid injection is not medically necessary because the injured worker lacks evidence for radiculopathy. The physical medicine Guideline recommends as follows: allow a fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Myalgia and myositis, unspecified (ICD9 729.1): 9-10 visits over 8 weeks. Neuralgia, neuritis, and radiculitis, unspecified (ICD9 729.2) 8-10 visits over 4 weeks. The injured worker has had an unspecified amount for this chronic injury.