MAXIMUS Federal Services

Case Number:	CM15-0198999		
Date Assigned:	10/14/2015	Date of Injury:	04/16/2003
Decision Date:	11/24/2015	UR Denial Date:	09/09/2015
Priority:	Standard	Application Received:	10/09/2015

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: Florida
Certification(s)/Specialty: Family Practice

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 50 year old female, who sustained an industrial injury on 4-16-03. The injured worker was diagnosed as having thoracic or lumbosacral neuritis or radiculitis, cervicocranial syndrome, and chronic pain. Treatment to date has included TENS and medication including Norco, Ultram ER, Cymbalta, and Elavil. On 7-22-15, the injured worker complained of back pain with radiation to the legs rated as 9 of 10. The treating physician requested authorization for lumbar epidural steroid injections, a lumbar facet injection, and physical therapy 2x6 for the lumbar spine. On 9-9-15 physical therapy was modified to certify 3 visits. The other requests were non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar ESI: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

Decision rationale: Criteria for the use of Epidural steroid injections: Note: The purpose of ESI is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). 3) Injections should be performed using fluoroscopy (live x-ray) for guidance. 4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections. 5) No more than two nerve root levels should be injected using transforaminal blocks. 6) No more than one interlaminar level should be injected at one session. 7) In the therapeutic phase, 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. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007) 8) Current research does not support a series-of-three injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections. Regarding this patient's case, MTUS guidelines state, "Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing." The medical records provided state that the patient had an MRI showing a herniated disc at L5-S1 with right sided radiculopathy. Unfortunately, the medical records provided do not have any physical exam findings present in the provided documentation. Only a subjective statement is provided, which states that "the pain goes down the right leg." Based on the medical documentation that has been provided, this request cannot be considered medically necessary at this time.

Lumbar facet injection: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back chapter, Facet joint diagnostic blocks (injections).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back chapter, lumbar facet diagnostic blocks (injections), Online edition 2015.

Decision rationale: This independent medical review has been requested to determine the medical necessity of a Lumbar Facet Injection. MTUS guidelines do not specifically address this request, and therefore the ODG guidelines were referenced. The ODG states that this type of injection is "limited to claimants with low back pain that is non-radicular and at no more than two levels bilaterally." There is no documentation regarding specific physical exam findings in this patient's case that would make this patient a candidate for a lumbar facet injection. Likewise, this request cannot be considered medically necessary.

Physical therapy 2 times 6 for the lumbar spine: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG GUIDELINES Physical Therapy. Online edition 2015.

Decision rationale: This independent medical review is to determine the medical necessity of 2 x 6 (a total of 12) physical therapy sessions for the lumbar spine. This patient has been given a diagnosis of "lumbosacral neuritis or radiculitis." The ODG guidelines specifically state regarding recommended physical therapy sessions, "Sciatica, thoracic/lumbosacral neuritis/radiculitis, unspecified: 10-12 visits over 8 weeks." This request is in accordance with ODG guidelines and is considered medically necessary.