

Case Number:	CM15-0221043		
Date Assigned:	11/16/2015	Date of Injury:	02/25/2013
Decision Date:	12/29/2015	UR Denial Date:	10/30/2015
Priority:	Standard	Application Received:	11/10/2015

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: Indiana, California

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 71 year old male who sustained an industrial injury on 02-25-2013. Medical records indicated the worker was treated for: protrusion L4-5 and L5-S1 with neural encroachment and left lumbar radiculopathy; left elbow lateral epicondylitis; bilateral knee pain secondary to patellofemoral chondromalacia-posttraumatic osteoarthropathy; status post inguinal hernia repair; rule out recurrent hernia. In the provider notes of 10-05-2015, the worker complained of worsening left shoulder pain rated an 8 on a scale of 0-10 with decline in activity and function. He denies re-injury or further injury but provides examples indicating activities of daily living are in jeopardy. He has low back pain with left lower extremity symptoms that he rates as a 6 on a scale of 0-10, left knee pain rated a 6 on a scale of 0-10, left elbow pain rated a 5 on a scale of 0-10, and right knee pain rated a 5 on a scale of 0-10. On examination, he has diffuse tenderness in the left shoulder with positive impingement signs and atrophy of the left deltoid muscle. Left shoulder flexion and abduction were 90 degrees each. External rotation and internal rotation are each 50 degrees. There is tenderness at the lumbar and lumboparaspinal musculature with lumbar range of motion of 45 degrees flexion, 30 degrees extension, left and right lateral tilt and left rotation are also 30 degrees. Straight leg raise on the left was positive for foot pain at 35 degrees. There was tenderness of the left lateral epicondyle. He had tenderness of the bilateral knees, medial and lateral aspect. His gait is antalgic. Range of motion of the knees is 0-110 degrees. The worker is getting his pain medications from a pain specialist. Treatment plan includes extracorporeal shockwave therapy for adhesive capsulitis refractory to injection

physical therapy, home exercise, activity modifications, NSAIDs, ice and heat. A request is made for diagnostic epidural injection L4-5 and L5-S1 with concurrent physical therapy lumbar spine, 3 times per week for 4 weeks. A request for authorization was submitted for: 1. Lumbar epidural injection L4-5 and L5-S1; 2. Physical therapy 3 times 4 to low back. A utilization review decision 10-30-2015 non-certified both requests.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar epidural injection L4-5 and L5-S1: Overturned

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

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Activity, Physical Methods, Work, Follow-up Visits, Special Studies, Surgical Considerations, Summary, and Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Epidural steroid injections (ESIs), therapeutic.

Decision rationale: MTUS Chronic pain medical treatment guidelines state that epidural steroid injections are "Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) . . . Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program." MTUS further defines the criteria for epidural steroid injections to include: 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. Radiculopathy does appear to be documented with imaging studies. The employee meets at least one of the above criteria, so the request is medically necessary.

Physical therapy 3 times 4 to low back: Upheld

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

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Activity, Work, Follow-up Visits, Special Studies, Surgical Considerations, Summary, Physical Methods, and Chronic Pain Medical Treatment 2009, Section(s): Manual therapy & manipulation. Decision based on Non-MTUS Citation Neck and Upper Back, Physical Therapy, ODG Preface - Physical Therapy.

Decision rationale: ACOEM guidelines advise against passive modalities by a therapist unless exercises are to be carried out at home by patient. ODG quantifies its recommendations with 10 visits over 8 weeks for lumbar sprains/strains and 9 visits over 8 weeks for unspecified backache/lumbago. ODG further states that a "six-visit clinical trial" of physical therapy with documented objective and subjective improvements should occur initially before additional sessions are to be warranted. Medical records indicate no initial trial of 6 sessions. Therefore, the request for 12 sessions is not medically necessary.