

Case Number:	CM15-0225317		
Date Assigned:	11/23/2015	Date of Injury:	05/18/2004
Decision Date:	12/31/2015	UR Denial Date:	11/11/2015
Priority:	Standard	Application Received:	11/17/2015

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: North Carolina
 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 78 year old, female who sustained a work related injury on 5-18-04. A review of the medical records shows she is being treated for low back pain. In the progress notes dated 10-13-15, the injured worker reports low back pain and left hip pain. She reports new pain in right ankle after a fall. Upon physical exam dated 10-13-15, she has tenderness of lumbar paraspinal muscles and lumbar facet joints. She has pain to palpation of left greater trochanteric bursa. She has decreased lumbar and left hip range of motion. She has normal sensation in legs. There is no documentation of radiating pain in either leg. Treatments have included medications, greater than 31 sessions of physical therapy-no notation of effectiveness of therapy, and lumbar epidural injections x 2 on 2-17-12 and 8-1-13-last one provided pain relief x 3 months. Current medications include Celebrex and Tramadol. No notation of working status. The treatment plan includes requests for lumbar epidural steroid injections, left hip injections and physical therapy. The Requests for Authorization dated 10-14-15 has requests for physical therapy x 24 sessions to hip and lumbar, for left L4 and L5 lumbar transforaminal epidural steroid injections and for left hip bursa injections. In the Utilization Review dated 11-11-15, the requested treatments of physical therapy x 24 sessions for hip and lumbar, lumbar transforaminal epidural injections at left L4 and L5 and left hip bursa injections are all not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Physical therapy times 24 sessions, hip and lumbar: Upheld

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

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

Decision rationale: Physical Medicine Guidelines: Allow for 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. Reflex sympathetic dystrophy (CRPS) (ICD9 337.2): 24 visits over 16 weeks. The goal of physical therapy is graduation to home therapy after a certain amount of recommended sessions. The patient has already completed physical therapy. The request is in excess of these recommendations per the California MTUS. There is no objective reason why the patient would not be moved to home therapy after completing the recommended amount of supervised sessions in the provided clinical documentation. Therefore, the request is not medically necessary.

Lumbar transforaminal epidural injections at left L4 L5: 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: The California Chronic Pain Medical Treatment Guidelines section on epidural steroid injections (ESI) states: 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. The provided clinical documentation for review does not show that previous ESI produced 50% reduction of pain lasting 6-8 weeks with decrease in medication usage. Therefore, the request is not medically necessary.

Left hip bursa injections: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines, Hip and pelvis regarding Trochanteric bursitis injections.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip, Bursitis.

Decision rationale: The California MTUS and the ACOEM do not specifically address the requested service. The ODG states that injection therapy is first line treatment for hip bursitis. The patient has physical findings consistent with greater trochanter bursitis. There are no documented contraindications. Therefore, the request is medically necessary.