

Case Number:	CM15-0038027		
Date Assigned:	03/06/2015	Date of Injury:	01/28/2008
Decision Date:	04/14/2015	UR Denial Date:	02/23/2015
Priority:	Standard	Application Received:	02/27/2015

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, California
 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 53-year-old female, who sustained an industrial injury on 01/28/2008. The diagnoses have included status post remote lumbar decompression, neural encroachment left L4-5 and L5-S1, right wrist carpometacarpal arthropathy, left medial epicondylitis of elbow and status post 3 prior surgeries of right foot with persistent right foot pain. Noted treatments to date have included surgeries, physical therapy, and medications. Diagnostics to date have included lumbar MRI on 10/04/2013, which showed moderate disc desiccation and shallow annular bulge at L2-L3 and 2mm anterolisthesis of L3 on L4 associated with severe bilateral hypertrophic facet changes at L3-L4 per orthopedic supplemental report dated 11/25/2014. In a progress note dated 01/16/2015, the injured worker presented with complaints of low back pain, left elbow pain, cervical pain, dorsal wrist pain, and compensatory left wrist/hand pain at 3-7/10 and Physical examination of the lumbar spine revealed limited range of motion. A detailed physical examination of the lumbar spine was not specified in the records provided. The treating physician reported that the injured worker's radicular component remains refractory. The medication list include Hydrocodone, Soma, Omeprazole, Ibuprofen and Flector patch. The patient's surgical history include lumbar decompression in 2011 and 3 right foot surgeries. The patient has had EMG/NCV study on 4/4/14 with normal findings.

IMR ISSUES, DECISIONS AND RATIONALES

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

Epidural injections left L4-L5 and Left L5-S1: 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 (ESIs) Page(s): 46.

Decision rationale: Request: Epidural injections left L4-L5 and Left L5-S1. The MTUS Chronic Pain Guidelines regarding Epidural Steroid Injections state, "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. 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. Per the cited guideline criteria for ESI are 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)." Radiculopathy documented by physical examination and corroborated by imaging studies and/or electro-diagnostic testing was not specified in the records provided. The patient has had EMG/NCV study on 4/4/14 with normal findings consistent objective evidence of lower extremity radiculopathy was not specified in the records provided. A detailed physical examination of the lumbar spine was not specified in the records provided. Any evidence of the radiculopathy, tingling, numbness in LE and positive SLR was not specified in the records provided. Any significant functional deficits of the low back that would require Epidural injections left L4-L5 and Left L5-S1 was not specified in the records provided. Lack of response to conservative treatment including exercises, physical methods, NSAIDs and muscle relaxants was not specified in the records provided. Patient has received an unspecified number of PT visits for this injury. Any conservative therapy notes were not specified in the records provided. A response to recent rehab efforts including physical therapy or continued home exercise program were not specified in the records provided. As stated above, 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. The records provided did not specify a plan to continue active treatment programs following the lumbar ESI. As stated above, ESI alone offers no significant long-term functional benefit. Any evidence of diminished effectiveness of medications or intolerance to medications was not specified in the records provided. With this, it is deemed that the medical necessity of request for Epidural injections left L4-L5 and Left L5-S1 is not fully established for this patient.

Additional physical therapy for the lumbar, three times weekly for four weeks: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical therapy Page(s): 98.

Decision rationale: Additional physical therapy for the lumbar, three times weekly for four weeks. The guidelines cited below state, "allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home physical medicine." Patient has received an unspecified number of PT visits for this injury. Previous conservative therapy notes were not specified in the records provided. The requested additional visits in addition to the previously certified PT sessions are more than recommended by the cited criteria. The records submitted contain no accompanying current PT evaluation for this patient. There was no evidence of ongoing significant progressive functional improvement from the previous PT visits that is documented in the records provided. Previous PT visits notes were not specified in the records provided. A detailed physical examination of the lumbar spine was not specified in the records provided. There was no objective documented evidence of any significant functional deficits that could be benefitted with additional PT. Per the guidelines cited, "Patients are instructed and expected to continue active therapies at home as an extension of the treatment process in order to maintain improvement levels." A valid rationale as to why remaining rehabilitation cannot be accomplished in the context of an independent exercise program is not specified in the records provided. The medical necessity of the request for Additional physical therapy for the lumbar, three times weekly for four weeks is not fully established for this patient.