

Case Number:	CM15-0043849		
Date Assigned:	03/13/2015	Date of Injury:	02/03/2014
Decision Date:	04/23/2015	UR Denial Date:	02/16/2015
Priority:	Standard	Application Received:	03/09/2015

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: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 25-year-old male patient, who sustained an industrial injury on 02/03/2014. A primary treating office visit dated 01/22/2015, reported objective findings showed lower extremities with decreased range of motion, 15/25 degrees in all directions; with pain. A straight leg raise was positive on the left leg at 35 degrees with radicular symptom to left foot. He has difficulty with heel toe walk. Assessment noted L5-S1 disc herniation to L4-5, foramen narrowing L-5 root contact with radicular left lower extremity symptom. The plan of care involved an L5-S1 epidural steroid injection times two. He is to remain off from work duty and participate in physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

L5-S1 epidural steroid injection with facet: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ESI Page(s): 46-47.

Decision rationale: The patient presents with low back pain. The request is for L5-S1 EPIDURAL STEROID INJECTION WITH FACET. The request for authorization is not provided. Provided progress report is a truncated one-page report with minimal information. Per UR letter dated, 02/16/15, MRI of the lumbar spine, 02/26/14, shows L5-S1 a moderate broad-based disc protrusion; causing moderate stenosis of the spinal canal; associated mild stenosis of the bilateral lateral recess; and moderate left greater than the right stenosis of the bilateral neural foramen that contact the visualized left L5 exiting nerve root. Physical examination to the lumbar spine reveals decreased range of motion in all directions with pain, straight leg raise on the left is positive. Per UR letter dated, 02/16/15, patient has had an injection and physical therapy with no benefit. The patient is not working. MTUS page 46, 47 states that an ESI is "Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy)." MTUS further states, "Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing." 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. Treater does not discuss the request. In this case, radiculopathy is documented by physical examination inpatient by positive straight leg raise test in progress report dated 01/22/15. Additionally, MRI of the lumbar spine, 02/26/14, shows L5-S1 a moderate broad-based disc protrusion; causing moderate stenosis of the spinal canal; associated mild stenosis of the bilateral lateral recess; and moderate left greater than the right stenosis of the bilateral neural foramen that contact the visualized left L5 exiting nerve root. However, per UR letter dated, 02/16/15, patient previously underwent an injection with no benefit. And treater does not provide any documentation or discussion regarding the previous injection or lack thereof. MTUS requires for repeat injections, documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks. Furthermore, the request is for facet injection as well and ODG does not support both ESI and facet injections at the same time. The request IS NOT medically necessary.

Post-operative physical therapy for the lumbar spine, three times weekly for three 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 medicine Page(s): 98-99.

Decision rationale: The patient presents with low back pain. The request is for POST-OPERATIVE PHYSICAL THERAPY FOR THE LUMBAR SPINE, THREE TIMES WEEKLY FOR THREE WEEKS. The request for authorization is not provided. Provided progress report is a truncated one-page report with minimal information. Per UR letter dated, 02/16/15, MRI of the lumbar spine, 02/26/14, shows L5-S1 a moderate broad-based disc protrusion; causing moderate stenosis of the spinal canal; associated mild stenosis of the bilateral lateral recess; and

moderate left greater than the right stenosis of the bilateral neural foramen that contact the visualized left L5 exiting nerve root. Physical examination to the lumbar spine reveals decreased range of motion in all directions with pain, straight leg raise on the left is positive. Per UR letter dated, 02/16/15, patient has had an injection and physical therapy with no benefit. The patient is not working. MTUS Chronic Pain Management Guidelines, pages 98,99 has the following: "Physical Medicine: recommended as indicated below. Allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. MTUS guidelines pages 98, 99 states that for "Myalgia and myositis, 9-10 visits are recommended over 8 weeks. For Neuralgia, neuritis, and radiculitis, 8-10 visits are recommended."Treater does not discuss the request. Treater does not provide any documentation of treatment history. In this case, treater's request is for post-operative physical therapy following the patient's epidural steroid injection. However, the epidural steroid injection is not authorized. Therefore, the request IS NOT medically necessary.

Pre-operative lab: urinalysis: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official disability guidelines Low Back - Lumbar & Thoracic (Acute & Chronic) Chapter, Criteria for Preoperative lab testing.

Decision rationale: The patient presents with low back pain. The request is for PRE-OPERATIVE LAB: URINALYSIS. The request for authorization is not provided. Provided progress report is a truncated one-page report with minimal information. Per UR letter dated, 02/16/15, MRI of the lumbar spine, 02/26/14, shows L5-S1 a moderate broad-based disc protrusion; causing moderate stenosis of the spinal canal; associated mild stenosis of the bilateral lateral recess; and moderate left greater than the right stenosis of the bilateral neural foramen that contact the visualized left L5 exiting nerve root. Physical examination to the lumbar spine reveals decreased range of motion in all directions with pain, straight leg raise on the left is positive. Per UR letter dated, 02/16/15, patient has had an injection and physical therapy with no benefit. The patient is not working. ODG-TWC, Low Back - Lumbar & Thoracic (Acute & Chronic) Chapter states: "Routine preoperative tests are defined as those done in the absence of any specific clinical indication or purpose and typically include a panel of blood tests, urine tests, chest radiography, and an electrocardiogram (ECG). These tests are performed to find latent abnormalities, such as anemia or silent heart disease that could impact how, when, or whether the planned surgical procedure and concomitant anesthesia are performed. It is unclear whether the benefits accrued from responses to true-positive tests outweigh the harms of false-positive preoperative tests and, if there is a net benefit, how this benefit compares to the resource utilization required for testing. An alternative to routine preoperative testing for the purpose of determining fitness for anesthesia and identifying patients at high risk of postoperative complications may be to conduct a history and physical examination, with selective testing based on the clinician's findings."Criteria for Preoperative lab testing:-Preoperative urinalysis is recommended for patients undergoing invasive urologic procedures and those undergoing implantation of foreign material. Treater does not discuss the request. In this case, treater's

request is for pre-operative urinalysis prior to the patient's epidural steroid injection. However, the epidural steroid injection is not authorized. Therefore, the request IS NOT medically necessary.