

Case Number:	CM15-0083693		
Date Assigned:	05/05/2015	Date of Injury:	03/23/2013
Decision Date:	06/04/2015	UR Denial Date:	05/01/2015
Priority:	Standard	Application Received:	05/01/2015

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 42-year-old male, who sustained an industrial injury on 3/23/13. The injured worker has complaints of chronic lower back pain radiating into bilateral legs, which occasionally get numb. The diagnoses have included lumbar radiculopathy and lumbar strain; degeneration of lumbar intervertebral disc; lumbosacral radiculitis and lumbago. Treatment to date has included magnetic resonance imaging (MRI) of the lumbar spine on 4/26/13 documented lumbar disc herniation at L4-L5; physical therapy that was noted on 4/17/15 provided minimal or temporary pain relief; epidural steroid injections; urinalysis is consistent with medications; oxycodone for pain and protonix. The request was for bilateral L4/5 L5/S1 thoracic epidural steroid injection and physical therapy two times six to the lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral L4/5 L5/S1 Thoracic Epidural Steroid Injection (ESI): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Steroid injections, page 46.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines recommend ESI as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy); however, radiculopathy must be documented on physical examination and corroborated by imaging studies and/or Electrodiagnostic testing. Although the patient has radicular symptoms with clinical findings of such, to repeat a LESI 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. Submitted reports are unclear with level of pain relief and duration of benefit. Submitted reports have not demonstrated any functional improvement derived from the LESI as the patient has unchanged symptom severity, unchanged clinical findings without decreased in medication profile or treatment utilization or functional improvement described in terms of increased functional status or activities of daily living. Criteria to repeat the LESI have not been met or established. The Bilateral L4/5 L5/S1 Thoracic Epidural Steroid Injection (ESI) is not medically necessary and appropriate.

Physical therapy (PT) 2 times 6 to the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy, pages 98-99.

Decision rationale: Physical therapy is considered medically necessary when the services require the judgment, knowledge, and skills of a qualified physical therapist due to the complexity and sophistication of the therapy and the physical condition of the patient. However, there is no clear measurable evidence of progress with the PT treatment already rendered including milestones of increased ROM, strength, and functional capacity. Review of submitted physician reports show no evidence of functional benefit, unchanged chronic symptom complaints, clinical findings, and functional status. There is no evidence documenting functional baseline with clear goals to be reached and the patient striving to reach those goals. The Chronic Pain Guidelines allow for visits of physical therapy with fading of treatment to an independent self-directed home program. It appears the employee has received significant therapy sessions without demonstrated evidence of functional improvement to allow for additional therapy treatments. There is no report of acute flare-up, new injuries, or change in symptom or clinical findings to support for formal PT in a patient that has been instructed on a home exercise program for this chronic injury. Submitted reports have not adequately demonstrated the indication to support further physical therapy when prior treatment rendered has not resulted in any functional benefit. The Physical therapy (PT) 2 times 6 to the lumbar spine is not medically necessary and appropriate.

