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| Case Number: | CM14-0166338 | | |
| Date Assigned: | 10/10/2014 | Date of Injury: | 06/01/2014 |
| Decision Date: | 11/12/2014 | UR Denial Date: | 09/26/2014 |
| Priority: | Standard | Application Received: | 10/07/2014 |

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. The expert reviewer is Board Certified in Preventive Medicine, and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

According to the records made available for review, this is a 33-year-old male with a 6/1/14 date of injury. At the time (8/20/14) of the request for authorization for series of 3 lumbar epidural injections of cortisone, additional physical therapy 3 times a week for 6 weeks to the lumbar spine, and nerve root block to lumbar spine, there is documentation of subjective (pain in the back with radiation to the left leg, numbness and tingling sensation in the leg) and objective (neck flexion causes pain in the lower back, moderate amount of spasm over the paravertebral muscles, sciatic notch is tender on the left side, decreased and painful lumbar spine range of motion) findings, imaging findings (8/20/14 medical report's reported imaging findings identify MRI revealed a central and left paramedian disc extrusion extending toward the left L5-S1 neural foramina. The left S1 nerve root appears to be pushed posteriorly by the extruded fragment (no imaging report is available for review)), current diagnoses (disc protrusion lumbar spine with radiculopathy, post-traumatic stress syndrome, and sleep disorder), and treatment to date (medication and physical therapy). Regarding series of 3 lumbar epidural injections of cortisone and nerve block to lumbar spine, there is no documentation of objective (sensory changes, motor changes, or reflex changes) radicular findings in the requested nerve root distribution and an imaging report. Regarding additional physical therapy 3 times a week for 6 weeks to the lumbar spine, the number of physical therapy sessions completed to date cannot be determined. In addition, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services with physical therapy completed to date.

IMR ISSUES, DECISIONS AND RATIONALES

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

Series of 3 lumbar epidural injections of cortisone: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Epidural Steroid Injections (ESIs)

Decision rationale: MTUS reference to ACOEM Guidelines identifies documentations of objective radiculopathy in an effort to avoid surgery as criteria necessary to support the medical necessity of epidural steroid injections. ODG identifies documentation of subjective (pain, numbness, or tingling in a correlating nerve root distribution) and objective (sensory changes, motor changes, or reflex changes (if reflex relevant to the associated level) in a correlating nerve root distribution) radicular findings in each of the requested nerve root distributions, imaging (MRI, CT, myelography, or CT myelography & x-ray) findings (nerve root compression OR moderate or greater central canal stenosis, lateral recess stenosis, or neural foraminal stenosis) at each of the requested levels, failure of conservative treatment (activity modification, medications, and physical modalities), and no more than two nerve root levels injected one session; as criteria necessary to support the medical necessity of lumbar transforaminal epidural steroid injection using fluoroscopy. Within the medical information available for review, there is documentation of diagnoses of disc protrusion lumbar spine with radiculopathy, post-traumatic stress syndrome, and sleep disorder. In addition, there is documentation of subjective (pain, numbness, and tingling) radicular findings in the requested nerve root distribution and failure of conservative treatment (activity modification, medications, and physical modalities). However, there is no documentation of objective (sensory changes, motor changes, or reflex changes) radicular findings in the requested nerve root distribution. In addition, despite the 8/20/14 medical report's reported imaging findings (MRI revealed a central and left paramedian disc extrusion extending toward the left L5-S1 neural foramina. The left S1 nerve root appears to be pushed posteriorly by the extruded fragment), there is no documentation of an imaging report. Furthermore, evidence based guidelines do not support a series of 3 injections. Therefore, based on guidelines and a review of the evidence, the request for series of 3 lumbar epidural injections of cortisone is not medically necessary.

Additional physical therapy 3 times a week for 6 weeks to the lumbar spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 98. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Physical therapy

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines support a brief course of physical medicine for patients with chronic pain not to exceed 10 visits over 4-8 weeks with allowance for fading of treatment frequency, with transition to an active self-directed program of independent home physical medicine/therapeutic exercise. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. ODG recommends a limited course of physical therapy for patients with a diagnosis of radiculitis not to exceed 12 visits over 8 weeks. ODG also notes patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy) and when treatment requests exceeds guideline recommendations, the physician must provide a statement of exceptional factors to justify going outside of guideline parameters. Within the medical information available for review, there is documentation of diagnoses of disc protrusion lumbar spine with radiculopathy, post-traumatic stress syndrome, and sleep disorder. In addition, there is documentation of previous physical therapy completed to date. However, the number of physical therapy sessions completed to date cannot be determined. In addition, there is no documentation of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services with physical therapy completed to date. Furthermore, if the number of physical therapy session completed to date exceeds guidelines, there is no documentation of a statement of exceptional factors to justify going outside of guideline parameters. Therefore, based on guidelines and a review of the evidence, the request for additional physical therapy 3 times a week for 6 weeks to the lumbar spine is not medically necessary.

Nerve root block to lumbar spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Epidural Steroid Injections (ESIs)

Decision rationale: MTUS reference to ACOEM Guidelines identifies documentations of objective radiculopathy in an effort to avoid surgery as criteria necessary to support the medical necessity of epidural steroid injections. ODG identifies documentation of subjective (pain, numbness, or tingling in a correlating nerve root distribution) and objective (sensory changes, motor changes, or reflex changes (if reflex relevant to the associated level) in a correlating nerve root distribution) radicular findings in each of the requested nerve root distributions, imaging (MRI, CT, myelography, or CT myelography & x-ray) findings (nerve root compression OR moderate or greater central canal stenosis, lateral recess stenosis, or neural foraminal stenosis) at each of the requested levels, failure of conservative treatment (activity modification, medications, and physical modalities), and no more than two nerve root levels injected one session; as criteria necessary to support the medical necessity of lumbar transforaminal epidural steroid injection using fluoroscopy. Within the medical information available for review, there is documentation of diagnoses of disc protrusion lumbar spine with radiculopathy, post-traumatic

stress syndrome, and sleep disorder. In addition, there is documentation of subjective (pain, numbness, and tingling) radicular findings in the requested nerve root distribution and failure of conservative treatment (activity modification, medications, and physical modalities). However, there is no documentation of objective (sensory changes, motor changes, or reflex changes) radicular findings in the requested nerve root distribution. In addition, despite the 8/20/14 medical report's reported imaging findings (MRI revealed a central and left paramedian disc extrusion extending toward the left L5-S1 neural foramina. The left S1 nerve root appears to be pushed posteriorly by the extruded fragment), there is no documentation of an imaging report. Furthermore, there is no documentation of the levels to be addressed. Therefore, based on guidelines and a review of the evidence, the request for nerve root block to lumbar spine is not medically necessary.