

Case Number:	CM14-0168008		
Date Assigned:	10/15/2014	Date of Injury:	09/28/2010
Decision Date:	11/18/2014	UR Denial Date:	10/02/2014
Priority:	Standard	Application Received:	10/13/2014

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 Physical Medicine & Rehabilitation, 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:

The patient was injured on 09/28/2010 but the mechanism of injury has not been provided. Her age has not been provided. Ortho note dated 08/21/2014 documented the patient presented with low back pain with left lower extremity symptoms rated as 8/10 and left knee pain rated as a 5/10. She was noted to be utilizing a LSO brace but it did improve her tolerance to perform activities of daily living. The patient is taking Tramadol ER 300 mg and Cyclobenzaprine which help to maintain her function and tolerance to activity such as light household duties, shopping for groceries, grooming and cooking; home exercise and tolerance to physical therapy. On exam, she has tenderness of the lumbar spine and limited range of motion with pain. She has a positive straight leg raise on the left. She also has spasm of the lumboparaspinal musculature. She is diagnosed with protrusion at left L5-S1 with radiculopathy. She has been recommended for an epidural injection L5-S1 and she was instructed to continue with physical therapy twice weekly for 4 weeks. Prior utilization review dated 10/02/2014 states the request for Outpatient Epidural Steroid Injection (ESI) Left L5-S1 and Outpatient Physical Therapy to Lumbar Spine 2 Times a Week for 4 Weeks is not certified as there is no documented evidence to support the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient epidural steroid injection (ESI) left L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections Page(s): 46.

Decision rationale: As per CA MTUS guidelines, 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. As per CA MTUS guidelines, Epidural steroid injections (ESIs) are recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). The criteria stated by the guidelines for the use of ESIs include: Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or Electrodiagnostic testing and initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). In this case, there is no clear clinical evidence of radicular symptoms in a nerve root distribution; i.e. in the requested level. There is no imaging evidence of nerve root compression. There is no electrodiagnostic evidence of radiculopathy. There is little to no documentation of trial and failure of conservative management such as physiotherapy. Therefore, the medical necessity of the request for ESI is not medically necessary.

Outpatient physical therapy to lumbar spine 2 times a week for 4 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 based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Physical Therapy (PT)

Decision rationale: As per CA MTUS guidelines, physical medicine is based on the philosophy that therapeutic exercise and/or activity are beneficial for restoring flexibility, strength, endurance, function, range of motion, and can alleviate discomfort. ODG guidelines recommend 9 visits over 8 weeks intervertebral disc disorders without myelopathy. In this case, the injury is old and the injured worker has already received unknown number of physical therapy visits. However, there is little to no documentation of any significant improvement in the objective measurements (i.e. pain level, range of motion, strength or function) with physical therapy to demonstrate the effectiveness of this modality in this injured worker. There is no evidence of presentation of any new injury / surgical intervention. Moreover, additional PT visits would exceed the guidelines criteria. Furthermore, there is no mention of the patient utilizing an HEP (At this juncture, this patient should be well-versed in an independently applied home exercise program, with which to address residual complaints, and maintain functional levels). Therefore, the request is considered not medically necessary or appropriate.

