

Case Number:	CM15-0116057		
Date Assigned:	08/03/2015	Date of Injury:	08/25/1999
Decision Date:	09/01/2015	UR Denial Date:	06/05/2015
Priority:	Standard	Application Received:	06/16/2015

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, Pain Management

CLINICAL CASE SUMMARY

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

This injured worker is a 69 year old male who reported an industrial injury on 8-25-1999. His diagnoses, and or impression, were noted to include: severe lumbar broad based disc with central canal stenosis; diffuse lumbosacral bulge; hypertrophic changes and spurring; displacement of cervical and lumbar inter-vertebral disc without myelopathy; and cervical spondylosis without myelopathy. No current imaging studies were noted. His treatments were noted to include: very effective "MBB" (9-12-12); diagnostic studies; medication management; and rest from work. The progress notes of 4-30-2015 reported a follow-up visit for continued bilateral neck pain that occasionally radiated to the shoulders, with stiffness, crackling and limited cervical spine range-of-motion; worsening low back pains that radiate down the right leg, with numbness, tingling and weakness; and bilateral knee pains. Objective findings were noted to include tenderness over the lumbar para-spinous muscles with restricted range-of-motion and positive right sciatic stretch test; decreased motor strength in the lower extremities; decreased sensation in the left cervical and right lumbosacral distributions; and compliant toxicology screening. The physician's requests for treatments were noted to include lumbosacral epidural steroid injections for low back and radicular pain. Notes indicate that the patient underwent an epidural steroid injection on July 28, 2015.

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 under fluoroscopic guidance: 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 Page(s): 46 of 127.

Decision rationale: Regarding the request for repeat Lumbar epidural steroid injection, Chronic Pain Medical Treatment Guidelines state that epidural injections are recommended as an option for treatment of radicular pain, defined as pain in dermatomal distribution with corroborative findings of radiculopathy, and failure of conservative treatment. Guidelines recommend that no more than one interlaminar level, or to transforaminal levels, should be injected at one session. Regarding repeat epidural injections, guidelines state that 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. Within the documentation available for review, there is no indication of at least 50% pain relief with associated reduction of medication use for 6 to 8 weeks as well as functional improvement from the most recent epidural injections. As such, the currently requested repeat lumbar epidural steroid injection is not medically necessary.

Physical therapy 1-2 x wk x 6 wks Lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical medicine Page(s): 98-99.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 298, Chronic Pain Treatment Guidelines Page(s): 98 of 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Physical Therapy.

Decision rationale: Regarding the request for additional physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, there is documentation of completion of prior PT sessions, but there is no documentation of specific objective functional improvement with the previous sessions and remaining deficits that cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. Furthermore, it is unclear how many therapy sessions the patient has already undergone making it impossible to determine if the patient has exceeded the maximum number recommended by guidelines for their diagnosis. In light of the above issues, the currently requested additional physical therapy is not medically necessary.

