

Case Number:	CM15-0096507		
Date Assigned:	05/27/2015	Date of Injury:	09/08/2009
Decision Date:	06/25/2015	UR Denial Date:	05/13/2015
Priority:	Standard	Application Received:	05/20/2015

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 70 year old male, who sustained an industrial injury on 9/8/2009. He reported low and mid back pain. The injured worker was diagnosed as having lumbar radiculopathy, lumbar herniated disc, lumbar degenerative disc disorder, and lumbar spondylosis. Treatment to date has included medications, and physical therapy. The request is for transforaminal epidural of the lumbar L5-S1 bilaterally, and physical therapy with electrical stimulation, and neuromuscular re-education. On 3/25/2015, he had low back and mid back pain with radiation into the left leg. He rated his pain 10/10 in severity. The treatment plan included: epidural, Flexeril, Norco, and Lyrica. On 5/4/2015, he complained of low back pain, right middle back pain. He rated his pain as 10/10 in severity and reported that it radiated to the bilateral lower extremities. He stated the pain is relieved by physical therapy, and medications. Physical finding noted he had a normal thoracic spine range of motion. The lumbar range of motion/normal is: forward bending flexion 40/60, backward bending extension 20/25, right lateral and left lateral bending 20/25. The hip/pelvis range of motion is noted to be reduced bilaterally. Testing noted a positive straight leg raise supine and sitting bilaterally. The treatment plan included: epidural, Norco, Flexeril, discontinuing Lyrica, and starting Neurontin.

IMR ISSUES, DECISIONS AND RATIONALES

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

Transforaminal epidural/lumbar L5-S1 bilaterally: 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 Epidural steroid injections (ESIs), 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, not provided here. Submitted reports have not demonstrated any correlating neurological deficits to support the epidural injections. Clinical findings indicate pain on range of motions with spasms; however, without any motor or sensory deficits. There is also no documented failed conservative trial of physical therapy, medications, activity modification, or other treatment modalities to support for the epidural injection. Lumbar epidural injections may be an option for delaying surgical intervention; however, there is not surgery planned or identified pathological lesion noted. The Transforaminal epidural/lumbar L5-S1 bilaterally is not medically necessary and appropriate.

Physical Therapy: electrical stimulation, neuromuscular re-education, 12 sessions: 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 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: electrical stimulation, neuromuscular re-education, 12 sessions is not medically necessary and appropriate.