

Case Number:	CM13-0021757		
Date Assigned:	12/04/2013	Date of Injury:	10/06/2011
Decision Date:	01/23/2014	UR Denial Date:	08/26/2013
Priority:	Standard	Application Received:	09/09/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation has a subspecialty in Interventional Spine 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 physician 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 is a 62 YO, male with a date of injury of 10/6/11. According to the 8/8/13 report from [REDACTED], the current diagnoses are bilateral lumbar radiculopathy, with fusion at L4-5; lumbar radiculitis at L2-3/testicular pain; left ribcage pain from fall; depression/anxiety; possible avascular necrosis of the left hip; bilateral total knee replacements; TBI; hx of cervical fracture. Presenting symptoms are low back and leg pain, left testicular pain, left ribcage pain, tightness throughout his back. Pain is present at all times with no pain-free period, which is worsened by movement and activity, but better with medication and rest. Spinal fusion was in May 2013, bilateral knee replacements from 2008, a rotator cuff surgery in 2002. Current medications are Lyrica, Norco 5/day, Cymbalta and Glipizide. Examination showed inability to stand on heels more than 1 s, not able to stand on ball of foot on left, absent DTR both knees, ankles, SLR were negative bilaterally. Motor exam showed decreased strength for ankle dorsiflexion and plantar flexion. Toe extension was weaker on left. MRI showed left lateral L2-3 herniation, spondylolisthesis at L4-5. The patient has had ESI's in the past but not at L2-3. The patient's MRI was from 5/30/13, showing laminotomies at L4-5 with hardware, pedicle screws; mild annular bulge at L2-3, small central protrusion L5-S1. Operative report is from 5/6/13. The treating physician is asking for caudal ESI and transforaminal ESI at L2-3 level. He believes there was a lateral disc at L2-3 that may be causing testicular pain. Request was also for an MRI of T-spine. MRI report from 5/30/13 notes "mild bilateral neural foraminal narrowing" at L2-3; mild central stenosis with bulging disc at L3-4; fusion at L4-5; very small central protrusion with annular fissure at L5-S1.

IMR ISSUES, DECISIONS AND RATIONALES

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

Thoracic MRI: Overturned

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation the Official Disability Guidelines (ODG), MRI Section.

Decision rationale: This patient presents with rib-cage pain and the treating physician has asked for an MRI of T-spine. The patient has failed with conservative care and has had thoracic pain for quite some time now without improvement. A disc herniation of the T-spine can certainly result in radiculopathy that often translates into rib-cage pain. Thoracic examinations are difficult in determining hard-evidence for nerve root lesion. Although MTUS and ACOEM guidelines do not address thoracic spine issues, the Official Disability Guidelines (ODG) do provide illumination under the Neck/Upper Back chapter, which provides guidance for MRI's. For chronic neck and upper back pain with neurologic symptoms, MRI is recommended. In this patient, radiating rib-cage pain is a neurologic symptom. Recommendation is for authorization.

**Lumbar epidural steroid injection-caudal approach, with lumbar myelography, lumbar epidurogram, fluoroscopic guidance, procedures to be done at Bay Surgery Center:
Upheld**

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46-47.

Decision rationale: The treating physician would like to perform caudal and transforaminal ESI on this patient who presents with chronic low back pain, bilateral lower extremities pain and left testicular pain. The patient underwent lumbar surgery with decompression and fusion at L4-5 in May 2013. The patient continues to experience pain and the updated MRI from 5/30/13 showed surgical changes at L4-5, bulging discs with mild bilateral foraminal stenosis at L2-3, and very small central disc protrusion at L5-S1. The treating physician believes that this patient has a lateral disc at L2-3 on the side of the patient's symptoms. The radiologic report did not describe a lateral disc at L2-3. The patient's examination showed relative weakness at the large toe and on left side, but SLR were negative and sensory exam was unremarkable. The California MTUS requires a diagnosis of radiculopathy for an ESI. In this case, while the patient clearly presents with "radicular" symptoms, or pain down the legs or extremities emanating from the spine, there is lack of evidence that "radiculopathy" is present. A diagnosis of radiculopathy require dermatomal distribution of pain/paresthesia, positive examination with corroborating imaging studies. In this case, the treating physician does not describe dermatomally distributed

pain/paresthesia. Instead, the patient's leg pains are non-specific. Examination findings do not support L2 or L3 radiculopathy. Weakness of the large toe is mostly L5 nerve root, and the patient has had surgery at L4-5 level. The updated MRI did not show a lateral disc per radiology review. There are no lesions at L5-S1 involving S1 nerve roots. Mild stenosis and foraminal narrowing would not cause radiculopathies. Given the lack of documentation of radiculopathy, recommendation is for denial.