

<b>Case Number:</b>	CM13-0029184		
<b>Date Assigned:</b>	04/25/2014	<b>Date of Injury:</b>	10/26/1995
<b>Decision Date:</b>	06/10/2014	<b>UR Denial Date:</b>	09/05/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/26/2013

### 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 and Rehabilitation, has a subspecialty in Inter 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 is a 63 year-old female with a 10/26/95 industrial injury claim. She has been diagnosed with lumbar disc disease, cervical disc disease, and cubital tunnel syndrome. According to the 11/29/13 orthopedic report from [REDACTED], the patient presents with a painful neck and lower back. The back pain was described as burning; it travels to the right thigh and is also noticeable in the left foot to toes. Right straight leg raise was positive, and Spurling's test was positive. [REDACTED] recommended lumbar epidural injections, aquatic therapy, a back brace, and medications.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **LUMBAR EPIDURAL STEROID INJECTION L1-2:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

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

**Decision rationale:** The patient presents with neck and lower back pain with a burning sensation going down the thighs, and to the toes. The physician has not identified a pattern of any specific nerve root compression. The L1 or L2 dermatome pattern does not typically radiate to the toes.

The straight leg raise was reported as positive, but the dermatomal pattern reproduced in the straight leg raise was not described. MRI shows disc protrusion at L1-2 with mild narrowing of the foramen bilaterally. There is mild central stenosis at L1-2 and L2-3, and moderate narrowing at L4-5. The MTUS Chronic Pain Medical Treatment Guidelines state that epidural steroid injections are recommended as an option for the treatment of radicular pain. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. The available records did not report a dermatomal distribution of pain. There were no exam findings of any neurologic deficits following a dermatomal or any specific radicular pattern. There are no electrodiagnostic studies provided, and the MRI findings did not show nerve compression nor did they correlate well with the physical exam findings. The MTUS criteria for an ESI has not been met. As such, the request is not medically necessary.

**INDEPENDENT AQUA THERAPY 3 TIMES A WEEK FOR 2 MONTHS:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 22, 98-99.

**Decision rationale:** The MTUS Chronic Pain Medical Treatment Guidelines state that aquatic therapy is recommended when reduced weight bearing is desirable. Guidelines further state that 8-10 sessions of physical therapy are recommended for various neuralgias and myalgias. The request for three times per week for two months will exceed the MTUS recommendations. As such, the request is not medically necessary.

**LUMBAR BACK BRACE QTY: 1:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301, 308. Decision based on Non-MTUS Citation Official Disability Guidelines.

**Decision rationale:** The MTUS/ACOEM guidelines state that lumbar supports are not beneficial beyond the acute phase of care. However, in this particular case, the MRI shows retrolisthesis of L2 on L3, without facet arthropathy, and shows 2-3mm anterolisthesis of L4 on L5 with bilateral facet arthropathy, and moderate central canal stenosis. The ACOEM did not discuss use of lumbar supports or braces with spondylolisthesis, so the Official Disability Guidelines were consulted. The ODG states that back braces are an option for the specific treatment of spondylolisthesis. The use of the lumbar brace in this case, is in accordance with ODG guidelines. As such, the request is medically necessary.