

<b>Case Number:</b>	CM13-0056079		
<b>Date Assigned:</b>	12/30/2013	<b>Date of Injury:</b>	12/14/2012
<b>Decision Date:</b>	08/25/2014	<b>UR Denial Date:</b>	11/08/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/21/2013

### 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 Pain Medicine and is licensed to practice in California and Virginia. 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 45 year-old male who sustained an industrial injury on 12/14/2012. An magnetic resonance imaging (MRI) of the thoracic spine on 3/15/2013 reveals: 1. Mild upper and mild thoracic spondylosis. 2. Small multilevel chronic appearing disc protrusions at T2-3, T3-4, T5-6, T7-8, and T8-9. 3. No significant resulting thoracic stenosis, cord compression, or other gross structural thoracic cord abnormality. 4. Incidental 1.7 cm left renal cyst. The patient had a pain management consult with [REDACTED] on 10/10/2013. He describes he sustained a sprain/pain through his spine on his date of injury. Based on a visual analog pain scale, the pain is rated 7/10, 9/10 at worst. He states pain affects mood, walking ability, normal work and sleep. Pain is described as burning, nagging, and sharp. His neck pain is tiring, and the mid-thoracic pain is constant and most bothersome. Physical examination reveals some limitation in cervical range of motion due to stiffness, back stiffness and increased pain with extension of thoracic spine, unremarkable upper and lower extremities, normal gait, unremarkable and normal toe raise and toe/heel walk. Thoracic and lumbar MRI results are documented. Diagnostic assessment: traumatic stress/sprain of cervical/thoracic/lumbar spine; degenerative disc disease, degenerative joint disease effecting the thoracic spine and lumbar spine. A request was made for continuous thoracic epidural with a catheter to thoracic T4-5-6 and 7. According to the 10/28/2013 progress report, the patient had a follow-up for neck and low back pain. He states he was recommended cervical and lumbar epidural injections by [REDACTED]. He states he was not comfortable with pain management physician, [REDACTED]. Examination documents palpation tenderness in cervical and lumbar region, slightly decreased cervical range of motion, strong C5 though T1 motor exam, normal reflexes, slightly decreased lumbar flexion and otherwise normal lumbar motion, and negative straight leg raise bilaterally. Treatment plan is

naproxen 550 mg #30, request authorization for consult and treatment for lumbar and/or cervical epidural steroid injections, regular work and followup in 3 weeks. According to the pain management progress report dated 6/16/2014, the patient returns with complaint of increasing neck pain. Still awaiting authorization for thoracic epidural steroid injections, T6-7. He still complains of the mid to upper back. He has previously had excellent but short term relief. He states mid back pain was completely relieved for 2-3 days then began to return, after previous injection. Pain returned to previous level after one week, he had some improvement in activities of daily living for 3 days. He does not take pain medications. The mid back pain is more intense than the low back. He continues to work full time. Pain is rated 6-7/10. Thoracic is worse with deep palpation and improved with extending his back. He has pain and discomfort in the entire spine. Physical examination reveals tenderness to palpation T6-11 spinous process, moderately stiff bilateral thoracic paraspinal muscles, and very stiff bilateral rhomboid muscles, left greater right. Objective findings are pain and discomfort of the lumbar spine; limited range of motion of the lumbar spine, painful range of motion of the lumbar spine. Diagnostic impression: 1. Mid back pain; 2. Thoracic disk protrusions 3. Mechanical low back pain; 4. Lumbar degenerative disk disease; 5. Mild lateral recess stenosis at L4-5; 6. Lumbar facet joint arthropathy; 7. Consider left sacroiliitis; 8. Myofascial pain syndrome; 9. Cervical spondylosis; 10. Occipital neuralgia. Treatment plan includes request for repeat thoracic epidural steroid injection at T6-7.

### **IMR ISSUES, DECISIONS AND RATIONALES**

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

**CONTINUOUS THORACIC ESI WITH FLUOROSCOPY WITH CATHETER 64440, 76003, 72265, 01995, 99080:** 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 Epidural Steroid Injections Page(s): 46.

**Decision rationale:** California Medical Treatment Utilization Schedule (MTUS) guidelines recommend Epidural Steroid Injections as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). As per the guidelines, the criteria for the use of epidural steroid injections include: Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. The medical records do not provide corroborative objective findings of active radiculopathy. The medical records do not reveal the presence of any subjective complaints nor objective findings that would indicate an active radiculopathy is present. Also, there is no evidence of a neurocompression lesion in the thoracic spine. The 3/15/2013 thoracic magnetic resonance imaging (MRI) reveals small multilevel disc protrusions without significant resulting thoracic stenosis or cord compression. The patient is not a candidate for thoracic epidural steroid injection (ESI). In addition, per the guidelines no more than two nerve root levels should be injected using transforaminal blocks and no more than one interlaminar level should be injected at one session. The request is excessive and is not supported by the guidelines. Furthermore, according to the guidelines, In the therapeutic phase, 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. According to the 6/16/2014 report, the patient apparently had T6-7 epidural injection, which provided 3-7 days pain relief. The patient did not obtain 6-8 weeks reduction in pain and improved function. Based on the guidelines and medical records, the request is not medically necessary; and the request is not medically necessary and appropriate.