

<b>Case Number:</b>	CM14-0159008		
<b>Date Assigned:</b>	10/02/2014	<b>Date of Injury:</b>	09/08/2005
<b>Decision Date:</b>	11/06/2014	<b>UR Denial Date:</b>	09/19/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/29/2014

### 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 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 underlying date of injury in this case is 09/08/2005. The date of the utilization review under appeal is 09/19/2014. The patient's treating diagnosis is degenerative disc disease at L4-S1. The patient was seen in treating physician followup 09/10/2014 with a severe flare of low back pain. Medications were noted to include Norco and Zanaflex. On exam, the patient noted JAMAR testing on the right at 12, 14, and 14 and on the left at 12, 14, and 12. Again, the patient was felt to have a flare-up of lumbosacral pain. The treatment plan included plans for an L4-S1 epidural steroid injection, noting that physical therapy and muscle relaxants have failed for about 2 years and that epidural steroid injections appear t be helpful for approximately 2 years.

### IMR ISSUES, DECISIONS AND RATIONALES

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

#### **Lumbar Epidural Steroid Injection Qty: 1: 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 Injection Page(s): 16.

**Decision rationale:** The Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines section on epidural injections, page 16, states that for initial epidural

injections, there should be symptoms, physical exam findings, and diagnostic studies which corroborate the presence of radiculopathy at a particular level. For repeat epidural injections, there should be specific documentation of verifiable pain and function improvement and medication reduction for at least 6-8 weeks. The medical records do not clearly outline neurological findings and diagnostic studies to support the presence of a focal radiculopathy. Additionally, there was only limited information provided regarding the benefit of past epidural injection treatment. For these reasons, the guidelines have not been met for the request epidural injection. This request is not medically necessary.

**Lumbar Facet Injection L4-5, Single Level Qty: 1: Upheld**

**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): 300.

**Decision rationale:** ACOEM Guidelines, Chapter 12, Low Back, page 300, states that invasive techniques including intraarticular facet injections are of questionable merit. The records do not provide an alternate rationale for this request. Moreover, it is not clear why a request would simultaneously be made for both facet injections and epidural injections, as it would be difficult clinically to distinguish symptoms of radicular versus facet-mediated etiology. Overall, the guidelines have not been met for a lumbar facet injection. This request is not medically necessary.

**Lumbar Facet Injection L5-S1, Additional Levels Qty: 1: Upheld**

**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): 300.

**Decision rationale:** ACOEM Guidelines, Chapter 12, Low Back, page 300, states that invasive techniques including intraarticular facet injections are of questionable merit. The records do not provide an alternate rationale for this request. Moreover, it is not clear why a request would simultaneously be made for both facet injections and epidural injections, as it would be difficult clinically to distinguish symptoms of radicular versus facet-mediated etiology. Overall, the guidelines have not been met for a lumbar facet injection. This request is not medically necessary.

**Anesthetic Injection Qty: 1: Upheld**

**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): 300.

**Decision rationale:** Since requests have been noncertified for both an epidural injection and for facet injections, the request for anesthetic injection is not applicable. This request is not medically necessary.

**Physical Therapy Lumbar Spine Post Procedure Qty: 6:** Upheld

**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): 300.

**Decision rationale:** Since this request is for postprocedure physical therapy and the request for procedures have been noncertified, it follows that this request for postprocedure physical therapy is not applicable. This request is not medically necessary.

**Urinalysis Qty: 1:** 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 Drug Testing Page(s): 43.

**Decision rationale:** The Medical Treatment Utilization Schedule Chronic Pain Medical Treatment Guidelines section on drug testing, page 43, recommends drug testing as an option to assess for the use or presence of illegal drugs. The medical records at this time contain very limited information regarding risk stratification for risks of aberrant behavior or the specific frequency for urine drug testing is planned and the drugs to be tested. Given this limited information, there is insufficient information to support this request for urinalysis. This request is not medically necessary.