

<b>Case Number:</b>	CM14-0175966		
<b>Date Assigned:</b>	10/29/2014	<b>Date of Injury:</b>	12/30/2008
<b>Decision Date:</b>	12/09/2014	<b>UR Denial Date:</b>	10/01/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/23/2014

### 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 Occupational Medicine 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:

According to the records made available for review, this is a 55-year-old male with a 12/30/08 date of injury and right L3-4 foraminal decompression on 3/27/14. At the time (8/6/14) of the request for authorization for outpatient lumbar physical therapy 2 times a week for 6 weeks and right L2-L3 transforaminal epidural steroid injection with pain management, there is documentation of subjective (right-sided lower back pain that radiates down into his right lateral thigh) and objective (decreased sensation in the right anterolateral aspect of his thigh) findings, imaging findings (MRI lumbar spine (6/11/14) report revealed right-sided laminotomy defects now noted at the L2-3 and L3-4 levels. Small central disk protrusion noted at the L2-3 level, slightly more prominent current examination. The central canal and neural foramina at the lower limits of normal in size. Slight annular bulging with marginal endplate ridging again noted at the L2-3 level. There is minor residual right-sided foraminal stenosis. Mild right-sided perithecal perineural fibrosis/scarring formation is noted), current diagnoses (right L3-4 foraminal decompression 3/27/14 and lumbosacral neuritis NOS), and treatment to date (medication). Medical reports identify the patient has yet to go to physical therapy after going through surgery. Regarding right L2-L3 transforaminal epidural steroid injection with pain management, there is no documentation of imaging (MRI, CT, myelography, or CT myelography & x-ray) findings (nerve root compression OR moderate or greater central canal stenosis, lateral recess stenosis, or neural foraminal stenosis) at the requested level and failure of additional conservative treatment (activity modification, physical modalities).

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Outpatient lumbar physical therapy 2 times a week for 6 weeks: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines Page(s): 98 of 127.

**MAXIMUS guideline:** Decision based on MTUS Postsurgical Treatment Guidelines Page(s): 26.

**Decision rationale:** MTUS Postsurgical Treatment Guidelines identifies up to 16 visits of post-operative physical therapy over 8 weeks and post-surgical physical medicine treatment period of up to 6 months. In addition, MTUS postsurgical treatment Guidelines identifies that the initial course of physical therapy following surgery is 1/2 the number of sessions recommended for the general course of therapy for the specified surgery. MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of a diagnosis of right L3-4 foraminal decompression 3/27/14 and lumbosacral neuritis NOS. However, the requested outpatient lumbar physical therapy 2 times a week for 6 weeks exceeds guidelines (for an initial course of physical therapy following surgery). Therefore, based on guidelines and a review of the evidence, the request for outpatient lumbar physical therapy 2 times a week for 6 weeks is not medically necessary.

**Right L2-L3 transforaminal epidural steroid injection with pain management: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation The Official Disability Duration Guidelines, Treatment in Workers Compensation, 2014 web-based edition.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Epidural Steroid Injections (ESIs)

**Decision rationale:** MTUS reference to ACOEM Guidelines identifies documentations of objective radiculopathy in an effort to avoid surgery as criteria necessary to support the medical necessity of epidural steroid injections. ODG identifies documentation of subjective (pain, numbness, or tingling in a correlating nerve root distribution) and objective (sensory changes, motor changes, or reflex changes (if reflex relevant to the associated level) in a correlating nerve root distribution) radicular findings in each of the requested nerve root distributions, imaging (MRI, CT, myelography, or CT myelography & x-ray) findings (nerve root compression OR moderate or greater central canal stenosis, lateral recess stenosis, or neural foraminal stenosis) at each of the requested levels, failure of conservative treatment (activity modification, medications, and physical modalities), and no more than two nerve root levels injected one session; as criteria necessary to support the medical necessity of lumbar transforaminal epidural steroid injection using fluoroscopy. Within the medical information available for review, there is documentation of a diagnosis of right L3-4 foraminal decompression 3/27/14 and lumbosacral

neuritis NOS. In addition, there is documentation of subjective (pain) and objective (sensory changes) radicular findings in the requested nerve root distribution, failure of conservative treatment (medications), and no more than two nerve root levels injected one session. However, given the documented imaging findings (MRI lumbar spine (6/11/14) report revealed right-sided laminotomy defects now noted at the L2-3 and L3-4 levels. Small central disk protrusion noted at the L2-3 level, slightly more prominent current examination. The central canal and neural foramina at the lower limits of normal in size. Slight annular bulging with marginal endplate ridging again noted at the L2-3 level. There is minor residual right-sided foraminal stenosis. Mild right-sided perithecal perineural fibrosis/scarring formation is noted), there is no documentation of imaging (MRI, CT, myelography, or CT myelography & x-ray) findings (nerve root compression OR moderate or greater central canal stenosis, lateral recess stenosis, or neural foraminal stenosis) at the requested level. In addition, there is no documentation of failure of additional conservative treatment (activity modification, physical modalities). Therefore, based on guidelines and a review of the evidence, the request for right L2-L3 transforaminal epidural steroid injection with pain management is not medically necessary.