

Case Number:	CM14-0086257		
Date Assigned:	08/08/2014	Date of Injury:	06/01/1990
Decision Date:	09/22/2014	UR Denial Date:	05/28/2014
Priority:	Standard	Application Received:	06/09/2014

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 Anesthesiology has a subspecialty in Pain Management 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 59-year-old female with a 6/1/90 date of injury and status posts multiple lower back surgeries (undated). At the time (5/7/14) of request for authorization for Thoracic Epidural Steroid Injection at T7-T8, Bilateral L4-L5 and L5-S1 Transforaminal Epidural Steroid Injection, MRI Thoracic Spine, MRI Lumbar Spine, LSO Brace, and Pool Therapy 24 Sessions (4X6), there is documentation of subjective (mid thoracic pain which radiates to the bilateral chest area, low back pain which radiates to the right lower leg along the bilateral L4, L5 and S1 distributions) and objective (midline and paraspinal pain in the mid thoracic spine radiating down to the lumbar spine, pain across the right lower back, and pain that radiates down at L4, L5, and S1 dermatomal distribution) findings, current diagnoses (thoracic radiculopathy along the bilateral T7-T8 area, lumbago, and lumbar radiculopathy, bilateral L4 and right L5 distribution), and treatment to date (spinal cord stimulator implantation with subsequent explanation, lumbar surgeries, and medication). Regarding Thoracic Epidural Steroid Injection at T7-T8 and Bilateral L4-L5 and L5-S1 Transforaminal Epidural Steroid Injection, there is no documentation of objective radicular findings in the requested nerve root distribution(s), imaging findings at the requested level(s), and failure of additional conservative treatment (activity modification and physical modalities). Regarding MRI thoracic spine and MRI lumbar spine, there is no documentation of red flag diagnoses; objective findings that identify specific nerve compromise on the neurologic examination, failure of conservative treatment, and a condition/diagnosis for which an MRI is

indicated (Thoracic spine trauma: with neurological deficit). Regarding LSO Brace, there is no documentation of compression fractures, spondylolisthesis, or documented instability. Regarding Pool Therapy 24 Sessions (4X6), there is no documentation of a clinical condition where reduced weight bearing is desirable (extreme obesity, need for reduced weight bearing, or recommendation for reduced weight bearing); and the proposed number of sessions exceeds guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Thoracic Epidural Steroid Injection at T7-T8: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections.

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 - Lumbar & Thoracic, 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 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 diagnoses of thoracic radiculopathy along the bilateral T7-T8 area, lumbago, and lumbar radiculopathy, bilateral L4 and right L5 distribution. In addition, there is documentation of subjective (pain) radicular findings in the requested nerve root distribution, failure of conservative treatment (medication), and no more than two nerve root levels injected one session. However, despite documentation of objective findings (midline and paraspinal pain in the mid thoracic spine radiating down to the lumbar spine, pain across the right lower back, and pain that radiates down at L4, L5, and S1 dermatomal distribution), there is no documentation of objective (sensory changes) radicular findings in the requested nerve root distribution. In addition, given documentation of an associated request for thoracic MRI, there is no documentation of imaging (MRI) findings (nerve root compression OR moderate or greater central canal stenosis, lateral recess stenosis, or neural foraminal stenosis) at the requested level. Furthermore, given documentation of an associated request for pool therapy, there is no documentation of failure of additional conservative treatment (physical modalities and activity modification). Therefore, based on guidelines and a review of the evidence, the request for Thoracic Epidural Steroid Injection at T7-T8 is not medically necessary.

Bilateral L4-L5 and L5-S1 Transforaminal Epidural Steroid Injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections.

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 - Lumbar & Thoracic, 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 diagnoses of thoracic radiculopathy along the bilateral T7-T8 area, lumbago, and lumbar radiculopathy, bilateral L4 and right L5 distribution. In addition, there is documentation of subjective (pain) radicular findings in the requested nerve root distributions, failure of conservative treatment (medication), and no more than two nerve root levels injected one session. However, despite documentation of objective findings (midline and paraspinal pain in the mid thoracic spine radiating down to the lumbar spine, pain across the right lower back, and pain that radiates down at L4, L5, and S1 dermatomal distribution), there is no documentation of objective (sensory changes, motor changes, or reflex changes) radicular findings in the requested nerve root distributions. In addition, given documentation of an associated request for lumbar MRI, there is no documentation of imaging (MRI) findings (nerve root compression OR moderate or greater central canal stenosis, lateral recess stenosis, or neural foraminal stenosis) at each of the requested levels. Furthermore, given documentation of an associated request for pool therapy, there is no documentation of failure of additional conservative treatment (physical modalities and activity modification). Therefore, based on guidelines and a review of the evidence, the request for Bilateral L4-L5 and L5-S1 Transforaminal Epidural Steroid Injection is not medically necessary.

MRI Thoracic Spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Neck and Upper Back regarding Magnetic Resonance Imaging (MRI).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic, Magnetic Resonance Imaging (MRI).

Decision rationale: MTUS reference to ACOEM Guidelines identifies documentation of red flag diagnoses where plain film radiographs are negative; objective findings that identify specific nerve compromise on the neurologic examination, failure of conservative treatment, and who are considered for surgery, as criteria necessary to support the medical necessity of an MRI. ODG identifies documentation of a condition/diagnosis (with supportive subjective/objective findings) for which an MRI is indicated (Thoracic spine trauma: with neurological deficit), as criteria necessary to support the medical necessity of a Thoracic MRI. Within the medical information available for review, there is documentation of diagnoses of thoracic radiculopathy along the bilateral T7-T8 area, lumbago, and lumbar radiculopathy, bilateral L4 and right L5 distribution. However, despite documentation of objective findings (midline and paraspinal pain in the mid thoracic spine radiating down to the lumbar spine, pain across the right lower back, and pain that radiates down at L4, L5, and S1 dermatomal distribution), and given documentation of an associated request for pool therapy and LSO brace, there is no documentation of red flag diagnoses; objective findings that identify specific nerve compromise on the neurologic examination, failure of conservative treatment, and a condition/diagnosis (with supportive objective findings) for which an MRI is indicated (Thoracic spine trauma: with neurological deficit). Therefore, based on guidelines and a review of the evidence, the request for MRI thoracic spine is not medically necessary.

MRI Lumbar Spine: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines Neck and Upper Back regarding Magnetic Resonance Imaging (MRI).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304.

Decision rationale: MTUS reference to ACOEM guidelines identifies documentation of red flag diagnoses where plain film radiographs are negative; objective findings that identify specific nerve compromise on the neurologic examination, failure of conservative treatment, and who are considered for surgery, as criteria necessary to support the medical necessity of MRI. Within the medical information available for review, there is documentation of diagnoses of thoracic radiculopathy along the bilateral T7-T8 area, lumbago, and lumbar radiculopathy, bilateral L4 and right L5 distribution. However, despite documentation of objective findings (midline and paraspinal pain in the mid thoracic spine radiating down to the lumbar spine, pain across the right lower back, and pain that radiates down at L4, L5, and S1 dermatomal distribution), and given documentation of an associated request for pool therapy and LSO brace, there is no documentation of red flag diagnoses; objective findings that identify specific nerve compromise on the neurologic examination, and failure of conservative treatment. Therefore, based on guidelines and a review of the evidence, the request for MRI lumbar spine is not medically necessary.

LSO Brace: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): Lumbar Supports.

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

Decision rationale: MTUS reference to ACOEM guidelines identifies documentation of red flag diagnoses where plain film radiographs are negative; objective findings that identify specific nerve compromise on the neurologic examination, failure of conservative treatment, and who are considered for surgery, as criteria necessary to support the medical necessity of MRI. Within the medical information available for review, there is documentation of diagnoses of thoracic radiculopathy along the bilateral T7-T8 area, lumbago, and lumbar radiculopathy, bilateral L4 and right L5 distribution. However, despite documentation of objective findings (midline and paraspinal pain in the mid thoracic spine radiating down to the lumbar spine, pain across the right lower back, and pain that radiates down at L4, L5, and S1 dermatomal distribution), and given documentation of an associated request for pool therapy and LSO brace, there is no documentation of red flag diagnoses; objective findings that identify specific nerve compromise on the neurologic examination, and failure of conservative treatment. Therefore, based on guidelines and a review of the evidence, the request for MRI lumbar spine is not medically necessary.

Pool Therapy 24 Sessions (4X6): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic Therapy.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine ; Aquatic therapy Page(s): 98; 22. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Aquatic therapy.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies that aquatic therapy is recommended where reduced weight bearing is desirable (such as extreme obesity, need for reduced weight bearing, or recommendation for reduced weight bearing), as criteria necessary to support the medical necessity of aquatic therapy. MTUS Chronic Pain Medical Treatment Guidelines support a brief course of physical medicine for patients with chronic pain not to exceed 10 visits over 4-8 weeks with allowance for fading of treatment frequency, with transition to an active self-directed program of independent home physical medicine/therapeutic exercise. 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. ODG identifies visits for up to 10 visits over 8 weeks in the management of intervertebral disc disorders. ODG also notes patients should be formally assessed after a "six-visit clinical trial" to see if the patient is moving in a positive direction, no direction, or a negative direction (prior to continuing with the physical therapy) and when treatment requests exceeds guideline recommendations, the physician must provide a statement of exceptional factors to justify going outside of guideline parameters. Within the medical information available for review, there is documentation of diagnoses of

thoracic radiculopathy along the bilateral T7-T8 area, lumbago, and lumbar radiculopathy, bilateral L4 and right L5 distribution. However, there is no documentation of a clinical condition where reduced weight bearing is desirable (extreme obesity, need for reduced weight bearing, or recommendation for reduced weight bearing). In addition, the proposed number of sessions exceeds guidelines. Therefore, based on guidelines and a review of the evidence, the request for Pool Therapy 24 Sessions (4X6) is not medically necessary.

