

<b>Case Number:</b>	CM14-0086746		
<b>Date Assigned:</b>	07/23/2014	<b>Date of Injury:</b>	08/28/2013
<b>Decision Date:</b>	10/14/2014	<b>UR Denial Date:</b>	05/22/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	06/10/2014

### 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 Family 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:

This is a 30-year-old male patient who reported an industrial injury on 8/28/2013, 13 months ago, attributed to the performance of his usual and customary job tasks. The patient complains of low back pain radiating to the right lower extremity. The patient also complains of neck pain. The patient is noted to be taking Norco, Ultram, and Naprosyn. The objective findings on examination included decreased range of motion of the lumbar spine; hyper-reflexia in the right upper extremity; positive SLR. The MRI of the lumbar spine dated 2/6/2014 documented L4-L5 degenerative disc disease with moderate size posterior central annular tear. The treatment plan included MRI of the cervical spine and a lumbar spine ESI at L4-L5.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**MRI cervical spine without contrast:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 182; 177-178. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) neck and upper back chapter-MRI

**Decision rationale:** The request for a MRI of the cervical spine was not supported with objective findings on examination to support medical necessity. The patient is 13 months s/p

DOI and has no documented neurological or radiculopathy deficits on examination. There was no objective evidence to support the medical necessity of the requested cervical spine MRI. The patient was not documented to have been provided complete conservative treatment. The criteria recommended by evidence-based guidelines were not documented to support the medical necessity of the requests. There is no rationale provided by the requesting provider to support the medical necessity of a MRI of the cervical spine as a screening study. There are no documented progressing neurological deficits. There are no demonstrated red flag diagnoses as recommended by the ACOEM Guidelines in order to establish the criteria recommended for a MRI of the cervical spine. The medical necessity of the requested MRI of the cervical spine was not supported with the subjective/objective findings recommend by the ACOEM Guidelines or the Official Disability Guidelines for the authorization of a cervical spine MRI. The patient's treatment plan did not demonstrate an impending surgical intervention or any red flag diagnoses. The treatment plan was not demonstrated to be influenced by the obtaining of the Cervical MRI. There were no demonstrated sensory or motor neurological deficits on physical examination; there were no demonstrated changes to the patient's neurological examination other than the subjective pain complaint; and the patient was not shown to have failed a conservative program of strengthening and conditioning. The patient is not documented as contemplating surgical intervention to the cervical spine. There were no documented clinical changes in the patient's clinical status or documented motor/sensory neurological deficits that would warrant the authorization of a MRI of the cervical spine/thoracic spine or meet the recommendations of the currently accepted evidence-based guidelines. There is no provided rationale for the MRI of the cervical spine/thoracic spine by the requesting provider. The MRI results were not noted to affect the course of the recommended conservative treatment. The functional assessment for the provided conservative therapy since the date of injury has not been documented or provided in the physical therapy documentation.

#### **Lumbar 4-5 Epidural Steroid Injections (ESI): 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; Updated chapter 179-80, Chronic Pain Treatment Guidelines Epidural Steroid injections Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Section low back chapter lumbar spine ESI

**Decision rationale:** The criteria required by the CA MTUS for the provision of a lumbar ESI were not documented by the requesting provider. The patient does meet the CA MTUS criteria for a lumbar ESI under fluoroscopic guidance. The use of lumbar spine ESIs is recommended for the treatment of acute or subacute radicular pain in order to avoid surgical intervention. The patient is not noted to have objective findings on examination consistent with a nerve impingement radiculopathy. The reported radiculopathy was not corroborated by imaging studies or Electrodiagnostic studies. There is no impending surgical intervention. The patient is being treated for chronic low back pain attributed to lumbar spine DDD. The patient is documented to of had a rehabilitation effort along with physical therapy; however, the last office visit documented reported neurological deficits along a dermatomal distribution to the bilateral lower

extremities; however, there was no corroboration with Electrodiagnostic or imaging studies. The stated diagnoses and clinical findings do not meet the criteria recommended by evidence-based guidelines for the use of a lumbar ESI by pain management. The CA MTUS requires that "Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing." The ACOEM Guidelines updated Back Chapter revised 8/08/08 does not recommend the use of lumbar ESIs for chronic lower back pain. The Official Disability Guidelines recommend that ESIs are utilized only in defined radiculopathies and a maximum of two lumbar diagnostic ESIs and a limited number of therapeutic lumbar ESIs are recommended in order for the patient to take advantage of the window of relief to establish an appropriate self-directed home exercise program for conditioning and strengthening. The criteria for a second diagnostic ESI is that the claimant obtain at least 50% relief from the prior appropriately placed ESI. The therapeutic lumbar ESIs are only recommended, "If the patient obtains 50-70% pain relief for at least 6-8 weeks." Additional blocks may be required; however, the consensus recommendation is for no more than four (4) blocks per region per year. The indications for repeat blocks include "acute exacerbations of pain or new onset of symptoms." Lumbar ESIs should be performed at no more than two levels at a session. Although epidural injection of steroids may afford short-term improvement in the pain and sensory deficits in patients with radiculopathy due to herniated nucleus pulposus, this treatment, per the guidelines, seems to offer no significant long-term functional benefit, and the number of injections should be limited to two, and only as an option for short term relief of radicular pain after failure of conservative treatment and as a means of avoiding surgery and facilitating return to activity. The patient is being treated for a subjective radiculitis with reported chronic low back without MRI or EMG/NCV evidence of a nerve impingement radiculopathy. There is no demonstrated medical necessity for a lumbar spine ESI for the reported chronic pain issues. The request for a lumbar spine LESI is not demonstrated to be medically necessary.