

<b>Case Number:</b>	CM14-0007590		
<b>Date Assigned:</b>	01/24/2014	<b>Date of Injury:</b>	06/20/2011
<b>Decision Date:</b>	03/17/2015	<b>UR Denial Date:</b>	11/18/2013
<b>Priority:</b>	Standard	<b>Application Received:</b>	12/17/2013

### 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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California, Arizona

Certification(s)/Specialty: Physical Medicine & Rehabilitation

### 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 injured worker is a 35-year-old male with a date of injury of 06/20/2011, and the mechanism of injury was a fall. His diagnoses were rule out cervical disc herniation, right shoulder subacromial impingement status post arthroscopic procedure with residual discomfort, chronic low back pain and radicular pain, status post 2 lumbar spine surgeries, and depression and anxiety. Past treatments include surgery, medications, therapy, psychiatric treatments, and injections. His past surgical history included left shoulder surgery in 2002, lumbar spine surgery in 2005, lumbar spine surgery in 2007, and right shoulder surgery in 2011. The injured worker reported on 10/30/2013 of complaints of pain in his neck, right shoulder, and right upper extremity, low back and bilateral extremities with pain in the low back that runs into both legs. He stated his pain is made worse by activities including standing, walking, and sitting for prolonged period of time. The pain is made better by massage and aquatic exercises. Physical examination revealed palpation of the cervical paraspinal was tender primarily on the right. Cervical flexion was limited by 25%, extension limited by 25%, lateral tilt to the right was limited by 35%, and to the left was limited by 25%. Rotation was limited by 25% to the left and 10% to the right. Examination of the lumbar spine revealed a well healed surgical scar over the lower part of the lumbar spine. Palpation of the paraspinal muscles was tender bilaterally. Flexion of the lumbar was limited to 45 degrees, extension to 10 degrees and painful, lateral tilt was limited by 35 degrees bilaterally. Deep tendon reflexes were normal. Motor strength was normal. Sensation was intact and normal. His current medications on 10/30/2013 were Gralise 600 mg, Pristiq 50 mg, alprazolam 25 mg, and tramadol 50 mg. The treatment plan was for

psychological and psychiatric treatment and functional restoration program. The recommendation was for an EMG of the upper extremities, as well as a cervical MRI. The rationale is because he has exacerbated his low back pain and his neck pain and radicular pain to the upper extremity, as well as right shoulder pain. He has numbness and tingling to the right upper extremity, as well as evidence of radiculopathy. The Request for Authorization form was not included.

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

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

#### **LUMBAR MYELOGRAPHY: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Myelography

**Decision rationale:** The request for lumbar myelography is not medically necessary. The injured worker presented with complaints of low back pain. The California MTUS Guidelines do not address the request. According to the Official Disability Guidelines, myelography is not recommended except in cases of demonstration of the site of a cerebrospinal fluid leak, surgical planning, especially in regard to the nerve roots; a myelogram can show whether surgical treatment is promising, radiation therapy planning, Diagnostic evaluation of spinal disease, poor correlation of physical findings with MRI studies, and use of MRI is precluded because of claustrophobia, technical issues, e.g., patient size, safety, e.g., pacemaker, or surgical hardware. There was no documentation of deficits which would meet the criteria for the myelography. As such, the request is not indicated. Therefore, the request for lumbar myelography is not medically necessary.

#### **LUMBAR EPIDUROGRAM: 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. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Epidural steroid injections (ESIs), therapeutic

**Decision rationale:** The request for lumbar epidurogram is not medically necessary. The injured worker presented with complaints of neck pain and low back pain. The injured worker had lack of documentation demonstrating evidence of objective findings of neurological deficit, such as decreased sensation, loss of strength, decreased deep tendon reflexes, and positive Spurling's. There is a lack of documentation demonstrating the injured worker has recent conservative

treatment. There is a lack of documentation submitted for this review. As such, the request is not medically necessary.

**EACH ADDITIONAL LEVEL X2:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**LUMBAR EPIDURAL STEROID INJECTION (ESI):** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines ESI's Page(s): 46.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

**Decision rationale:** The request for LUMBAR EPIDURAL STEROID INJECTION (ESI) is not medically necessary. The injured worker presented with complaints of low back pain. The California MTUS Guidelines recommend an ESI as an option for treatment of radicular pain. Criteria for use of an epidural steroid injection are radiculopathy must be documented by physical examination and corroborated by imaging studies, be initially unresponsive to conservative treatment, and injections should be performed using fluoroscopy, and no more than 2 nerve root levels should be injected using transforaminal blocks. The clinical notes lack evidence of objective findings of radiculopathy, numbness, weakness, and loss of strength. There was no radiculopathy documented by physical examination. There was lack of documentation of the injured worker's initial unresponsiveness to conservative treatment which would include exercises, physical methods, and medications. The request did not indicate the use of fluoroscopy for guidance in the request. As such, the request is not medically necessary.