

<b>Case Number:</b>	CM14-0192050		
<b>Date Assigned:</b>	11/25/2014	<b>Date of Injury:</b>	08/15/2011
<b>Decision Date:</b>	01/14/2015	<b>UR Denial Date:</b>	11/11/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/17/2014

### 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 Preventive Medicine, has a subspecialty in Occupational Medicine and is licensed to practice in Texas. 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 injured worker is a 60 year old male who was injured at work on 08/15/2011. He is reported to have developed 3/10 neck pain since the past three months. The neck pain is believed to be caused by shoulder problems. In addition to the neck pain, he also complained of pain in his lower back, right shoulder and arm. The physical examination revealed diminished sensations in the mid-anterior, mid-lateral calf, and lateral ankle and also positive straight leg raise in the right lower extremity. The MRI of the lumbar spine revealed subtle flattening of the thecal sac at L3-4, and L4-5, mild encroachment upon the intervertebral bilaterally and slight desiccation of the L4-5 disc, however, the height of the disc appears to be well preserved. The electro diagnostic study was reported as mild acute right C6 and L5 radiculopathy. The worker has been diagnosed of Lumbar spine disc bulge with radiculopathy, right shoulder strain. Treatments have included epidural steroid injection on 05/02/2014. At dispute are the requests for Lumbar epidural steroid injections L4-S1 #3; PT 1x6 Lumbar Spine and Right shoulder; Medication consultation; Sleep study consultation.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lumbar epidural steroid injections L4-S1 #3:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of Epidural steroid injections Page(s): 46.

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

**Decision rationale:** The injured worker sustained a work related injury on 08/15/2011. The medical records provided indicate the diagnosis of Lumbar spine disc bulge with radiculopathy, right shoulder strain. Treatments have included epidural steroid injection on 05/02/2014, which provided 50% improvement in pain. The medical records provided for review do not indicate a medical necessity for Lumbar epidural steroid injections L4-S1 #3. Although the physical finding is corroborated with electro diagnostic finding of radiculopathy (as is recommended by the MTUS), the documents reviewed did not provide any information on how he benefited from the previous epidural injections. The MTUS recommends that repeat blocks be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks. Furthermore, the MTUS additionally recommends a maximum of 2 blocks, because current research does not support series-of-three injections in either the diagnostic or therapeutic phase.

**PT 1x6 Lumbar Spine and Right shoulder:** Overturned

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98.

**Decision rationale:** The injured worker sustained a work related injury on 08/15/2011. The medical records provided indicate the diagnosis of Lumbar spine disc bulge with radiculopathy, right shoulder strain. Treatments have included epidural steroid injection on 05/02/2014. The medical records provided for review do indicate a medical necessity for Lumbar for PT 1x6 Lumbar Spine and Right shoulder. The MTUS recommends a fading treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. Therefore, the requested treatment is medically necessary and appropriate.

**Medication consultation:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Introduction Page(s): 6.

**Decision rationale:** The injured worker sustained a work related injury on 08/15/2011. The medical records provided indicate the diagnosis of Lumbar spine disc bulge with radiculopathy, right shoulder strain, Calcific Tendinosis of the rotator cuff, right shoulder per MRI of 10/20/2011, right peroneal neuropathy. Treatments include epidural steroid injection on 05/02/2014. The medical records provided for review do not indicate a medical necessity for Medication consultation. Although the MTUS recommends reevaluation of patients with delayed

healing and a consideration of referral to the resources capable of addressing medical and psychosocial barriers to recovery, the records reviewed did not provide any information about other measures that have been tried and failed. Therefore, the requested treatment is not medically necessary and appropriate.

**Sleep study consultation:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Criteria for Polysomnography

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) < Pain (Chronic) >, < Polysomnography >

**Decision rationale:** The injured worker sustained a work related injury on 08/15/2011. The medical records provided indicate the diagnosis of Lumbar spine disc bulge with radiculopathy, right shoulder strain. Treatments have included epidural steroid injection on 05/02/2014. The medical records provided for review do not indicate a medical necessity for Sleep study consultation. The MTUS is silent on sleep study; however, the official Disability Guidelines recommends the use of sleep study for certain insomnia complaints. These include insomnia complaint for at least six months (at least four nights of the week), unresponsive to behavior intervention and sedative/sleep-promoting medications and psychiatric etiology has been excluded. The guidelines recommends against sleep study for the sole complaint of snoring. Therefore, the requested study is not medically necessary since the documents reviewed do not indicate the injured worker suffers from insomnia meeting the required criteria.