MAXIMUS Federal Services

| Case Number: | CM15-0142665 | | |
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| Date Assigned: | 08/03/2015 | Date of Injury: | 09/17/2004 |
| Decision Date: | 08/31/2015 | UR Denial Date: | 07/22/2015 |
| Priority: | Standard | Application Received: | 07/23/2015 |

## 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: Arizona, California
Certification(s)/Specialty: Family Practice

## 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 52 year old male with an industrial injury dated 09-17-2004. His diagnoses included reflex sympathetic dystrophy lower limb, myospasm above fusion, lumbago, post laminectomy syndrome, lumbosacral neuritis. Comorbid condition was hyperthyroidism. Prior treatment included epidural steroid injection, heat treatment, physical therapy, TENS (nerve stimulator) trigger point injection, facet joint injection and acupuncture. His current medications were Skelaxin, Norco, Soma, Celebrex, Synthroid, Lidoderm, Halcion and Synthroid. He presents on 07-14-2015 with complaints of bilateral leg pain and numbness feeling in back of legs and into feet. Leg pain drives him "insane." The injured worker had a "rough" night on Sunday night prior to the visit with pain rated ad 6-7 out of 10. He also noted lumbar spine pain rated as 6 out of 10. He reports decreased pain in right and left sciatica and increased pain in the bilateral feet described as burning. He was currently working. Physical exam noted two plus reflexes and symmetric at the biceps, brachioradialis, triceps, patellar and Achilles and bilateral lower extremity radiculopathy. The treatment plan included physical therapy, medications, lumbar epidural steroid injection, MRI and labs, nerve root block and follow up. The treatment requests for lab: Thyroid panel Qty: 1.00 and MRI of lumbar spine with contrast Qty: 1.00 was authorized. The treatment requests for review are as follows: Nerve root block bilateral L 5 Qty: 1.00; Physical therapy Qty: 6.00; Transforaminal epidural steroid injection left and right L 5 Qty: 1.00.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Physical therapy Qty: 6.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Physical Medicine Guidelines Page(s): 98-99.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 29, Chronic Pain Treatment Guidelines physical medicine Page(s): 98-99.

**Decision rationale:** According to the MTUS guidelines, therapy is recommended in a fading frequency. They allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. The following diagnoses have their associated recommendation for number of visits. Myalgia and myositis, unspecified 9-10 visits over 8 weeks. Neuralgia, neuritis, and radiculitis, unspecified 8-10 visits over 4 weeks. Reflex sympathetic dystrophy (CRPS). 24 visits over 16 weeks. According to the ACOEM guidelines: Physical and Therapeutic Interventions are recommended for 1 to 2 visits for education. This education is to be utilized for at home exercises which include stretching, relaxation, strengthening exercises, etc. There is no documentation to indicate that the sessions provided cannot be done independently by the claimant at home. The claimant had undergone numerous physical therapy sessions in the past. Consequently, additional therapy sessions are not medically necessary.

**Nerve root block bilateral L5 Qty: 1.00:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs) Page(s): 46.

**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 chapter and pg 36.

**Decision rationale:** According to the guidelines, Criteria for the use of diagnostic blocks for facet "mediated" pain: Clinical presentation should be consistent with facet joint pain, signs & symptoms. 1. One set of diagnostic medial branch blocks is required with a response of 70%. The pain response should last at least 2 hours for Lidocaine. 2. Limited to patients with low-back pain that is non-radicular and at no more than two levels bilaterally. 3. There is documentation of failure of conservative treatment (including home exercise, PT and NSAIDs) prior to the procedure for at least 4-6 weeks. 4. No more than 2 facet joint levels are injected in one session (see above for medial branch block levels). 5. Recommended volume of no more than 0.5 cc of injectate is given to each joint. 6. No pain medication from home should be taken for at least 4 hours prior to the diagnostic block and for 4 to 6 hours afterward. 7. Opioids should not be given as a "sedative" during the procedure. 8. The use of IV sedation (including other agents such as midazolam) may be grounds to negate the results of a diagnostic block, and should only be given in cases of extreme anxiety. 9. The patient should document pain relief with an instrument such as a VAS scale, emphasizing the importance of recording the maximum pain relief and maximum duration of pain. The patient should also keep medication use

and activity logs to support subjective reports of better pain control. 10. Diagnostic facet blocks should not be performed in patients in whom a surgical procedure is anticipated. (Resnick, 2005) 11. Diagnostic facet blocks should not be performed. In this case, the claimant has noted radiculopathy and history of fusion which would obviate the necessity for a nerve block. In addition, the claimant has had numerous invasive procedures and the short term relief attained from them would also make the bilateral nerve blocks unnecessary.

**Transforaminal epidural steroid injection left and right L5 Qty: 1.00:** Overturned

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs) Page(s): 46.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines epidural injections Page(s): 47.

**Decision rationale:** According to the guidelines, the criteria for the use of Epidural steroid injections: Note: The purpose of ESI is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). 3) Injections should be performed using fluoroscopy (live x-ray) for guidance. 4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections. 5) No more than two nerve root levels should be injected using transforaminal blocks. 6) No more than one interlaminar level should be injected at one session. 7) In the therapeutic phase, repeat blocks should 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 per region per year. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007) 8) Current research does not support a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections. In this case, the claimant has under gone numerous ESI. The claimant does have radicular symptoms and persistent pain with good results from ESI which provide lasting benefit. The request for another ESI is appropriate.