

Case Number:	CM15-0162203		
Date Assigned:	08/28/2015	Date of Injury:	09/04/1987
Decision Date:	09/30/2015	UR Denial Date:	07/28/2015
Priority:	Standard	Application Received:	08/18/2015

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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 45 year old female, who sustained an industrial injury on 9-4-1987. Diagnoses have included herniated nucleus pulposus (HNP), lumbago, radiculitis and failed back surgery syndrome. Treatment to date has included spinal fusion, physical therapy, magnetic resonance imaging (MRI), injections and medication. According to the progress report dated 7-15-2015, the injured worker complained of continued low back pain radiating down her right side. The pain was minimally relieved by medication. She reported that she had stopped exercising due to pain. Physical exam revealed tenderness to palpation over the right side of her facet as well as tenderness over the piriformis and over her right hamstring. There was decreased sensation in the right leg L5-S1 distribution. The injured worker was given trigger point injections. Authorization was requested for lumbar myelogram with computed tomography scan, caudal epidural transforaminal injection and physical therapy once a week for six weeks for the lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar myelogram with CT Scan: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Criteria for Myelography and CT Myelography.

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 - Lumbar & Thoracic (Acute & Chronic), Myelography.

Decision rationale: The claimant has a remote history of a work injury occurring in September 1987 and continues to be treated for radiating low back pain including a diagnosis of failed back surgery syndrome. When seen, lumbar spine surgery was being considered. She had undergone an MRI of the lumbar spine which was a suboptimal study due to metallic artifact. Physical examination findings included right lumbar facet, piriformis and right hamstring tenderness. There was decreased lumbar range of motion and decreased right lower extremity sensation. Authorization for a caudal epidural and transforaminal injection, physical therapy, and a CT myelogram was requested. Criteria for a CT myelogram of the lumbar spine include when being requested for surgical planning, especially in regard to the nerve roots and when an MRI precluded because of surgical hardware. In this case, further lumbar spine surgeries being considered and the claimant has metallic hardware interfering with magnetic resonance imaging. The requested CT myelogram is medically necessary.

Caudal epidural transforaminal injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of Epidural steroid injections, p46 Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back-Lumbar & Thoracic (Acute & Chronic), Epidural steroid injections, diagnostic.

Decision rationale: The claimant has a remote history of a work injury occurring in September 1987 and continues to be treated for radiating low back pain including a diagnosis of failed back surgery syndrome. When seen, lumbar spine surgery was being considered. She had undergone an MRI of the lumbar spine which was a suboptimal study due to metallic artifact. Physical examination findings included right lumbar facet, piriformis and right hamstring tenderness. There was decreased lumbar range of motion and decreased right lower extremity sensation. Authorization for a caudal epidural and transforaminal injection, physical therapy, and a CT myelogram were requested. In terms of the requested injections, the caudal epidural injection is being requested is a therapeutic procedure. The transforaminal epidural injections are actually intended to be selective nerve root blocks and would be considered a diagnostic injection. ODG addresses diagnostic epidural steroid injections which were originally developed as a diagnostic technique to determine the level of radicular pain. Criteria include identifying the origin of pain in patients who have had previous spinal surgery. Criteria for the use of epidural steroid injections include that radiculopathy be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. In this case, the claimant's provider

documents decreased right lower extremity sensation. However, additional imaging has been requested and whether this result would correlate with the claimant's symptoms and physical examination findings is unknown. The caudal epidural steroid injection is not medically necessary at this time. Additionally, performing both diagnostic and therapeutic injections at the same time would not be appropriate. The request is not medically necessary.

Physical therapy 1xwk x 6 wks, Lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low back, Lumbar & Thoracic (Acute & Chronic) - Physical therapy (PT).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (1) Chronic pain, Physical medicine treatment. (2) Preface, Physical Therapy Guidelines.

Decision rationale: The claimant has a remote history of a work injury occurring in September 1987 and continues to be treated for radiating low back pain including a diagnosis of failed back surgery syndrome. When seen, lumbar spine surgery was being considered. She had undergone an MRI of the lumbar spine which was a suboptimal study due to metallic artifact. Physical examination findings included right lumbar facet, piriformis and right hamstring tenderness. There was decreased lumbar range of motion and decreased right lower extremity sensation. Authorization for a caudal epidural and transforaminal injection, physical therapy, and a CT myelogram were requested. Recent treatments included physical therapy with an initial evaluation in March 2015. The claimant is being treated for chronic pain with no new injury and has recently had physical therapy. Patients are expected to continue active therapies and compliance with an independent exercise program would be expected without a need for ongoing skilled physical therapy oversight. An independent exercise program can be performed as often as needed/appropriate rather than during scheduled therapy visits. In this case, the number of additional visits requested is in excess what might be needed to reestablish or revise the claimant's home exercise program. Skilled therapy in excess of that necessary could promote dependence on therapy provided treatments. The request is not medically necessary.