

<b>Case Number:</b>	CM15-0192036		
<b>Date Assigned:</b>	10/06/2015	<b>Date of Injury:</b>	12/08/2014
<b>Decision Date:</b>	11/18/2015	<b>UR Denial Date:</b>	09/21/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/29/2015

### 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: California  
 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 50 year old male who sustained an industrial injury on 12-8-14. The injured worker reported pain in the back with lower extremity radiation and right upper extremity. A review of the medical records indicates that the injured worker is undergoing treatments for cervical and lumbar degenerative disc disease, lumbar radiculopathy. Medical records dated 9-2-15 indicate pain rated at 4 out of 10. Provider documentation dated 9-2-15 noted the work status as returning "back to work full duty on a trial basis". Treatment has included electromyography, at least eight sessions of physical therapy, at least 12 sessions of chiropractic treatments, and magnetic resonance imaging. Provider documentation dated 9-2-15 noted the injured worker was "currently not taking any medications." Objective findings dated 9-2-15 were notable for positive FABER testing on the right. Provider documentation noted the injured worker reported "having more pain in his arms below the elbows on both sides, pain is going from his lower back into the right lower extremity." The original utilization review (9-21-15) denied a request for Lumbar steroid injection L4-5 and Physical therapy 2 times a week for 4 weeks for the lumbar and cervical.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Lumbar steroid injection L4-5:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

**Decision rationale:** The patient presents on 09/02/15 with lower back pain which radiates into the right lower extremity. The patient's date of injury is 12/08/14. The request is for lumbar steroid injection L4-5. The RFA is dated 09/02/15. Physical examination dated 09/02/15 reveals tenderness to palpation of the lumbar spine from L1 level to sacrum with spasms noted bilaterally, negative straight leg raise test bilaterally, positive FABER, thigh thrust, and distraction tests on the right. Neurological examination reveals intact light touch sensation in all dermatomes of the bilateral lower extremities. The patient is not currently taking any medications. Patient is currently advised to return to full duties for a trial period. MTUS Guidelines, Epidural Steroid Injections section, page 46: "Criteria for the use of Epidural steroid injections: 1. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing, 3. Injections should be performed using fluoroscopy (live x-ray) for guidance, 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 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. In this case, the treater is requesting an initial lumbar ESI at the L4-5 level for the management of this patient's chronic lower back pain with a radicular component. There is no evidence in the records provided that this patient has undergone any ESIs to date. Per progress note dated 09/02/15, the provider documents subjective complaints of pain which radiates into the right lower extremity, however the physical examination does not include any evidence of neurological deficit in the bilateral lower extremities. Diagnostic MRI dated 05/23/15 notes a 1-2mm disc bulge with no foraminal stenosis or nerve root abutment at the L4-5 levels. It is not clear why the provider would request a lumbar ESI at these levels given the lack of neurological compromise and unremarkable MRI findings. MTUS guidelines require clear documentation of physical examination findings indicating neurological compromise in a specific dermatomal distribution, and MRI evidence of foraminal stenosis/nerve root abutment at the requested levels. Without such documentation, this request cannot be substantiated. Therefore, the request is not medically necessary.

**Physical therapy 2 times a week for 4 weeks for the lumbar and cervical:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines, Neck and Upper Back (updated 06/25/15) Physical Therapy, Low Back (updated 07/17/15), Physical Therapy.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine.

**Decision rationale:** The patient presents on 09/02/15 with lower back pain which radiates into the right lower extremity. The patient's date of injury is 12/08/14. The request is for physical therapy 2 times A week for 4 weeks for the lumbar and cervical. The RFA is dated 09/02/15. Physical examination dated 09/02/15 reveals tenderness to palpation of the lumbar spine from L1 level to sacrum with spasms noted bilaterally, negative straight leg raise test bilaterally, positive FABER, thigh thrust, and distraction tests on the right. Neurological examination reveals intact light touch sensation in all dermatomes of the bilateral lower extremities. The patient is not currently taking any medications. Patient is currently advised to return to full duties for a trial period. MTUS Guidelines, Physical Medicine Section, pages 98, 99 has the following: "recommended as indicated below. Allow for fading of treatment frequency from up to 3 visits per week to 1 or less, plus active self-directed home Physical Medicine." MTUS guidelines pages 98, 99 states that for "Myalgia and myositis, 9-10 visits are recommended over 8 weeks. For Neuralgia, neuritis, and radiculitis, 8-10 visits are recommended." In regard to the 8 physical therapy sessions for this patient's ongoing lower back pain, the provider has exceeded guideline recommendations. This patient has had at least 8 sessions of physical therapy for his lower back complaint to date. For chronic pain complaints, MTUS guidelines support 8-10 physical therapy treatments. The request for 8 treatments in addition to the 8 already completed exceeds these recommendations and cannot be substantiated. It is not clear why this patient is unable to transition to home-based/self-directed therapy, either. Therefore, the request is not medically necessary.