

<b>Case Number:</b>	CM15-0204927		
<b>Date Assigned:</b>	10/21/2015	<b>Date of Injury:</b>	08/12/2014
<b>Decision Date:</b>	12/10/2015	<b>UR Denial Date:</b>	09/28/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/19/2015

### 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, District of Columbia, Maryland

Certification(s)/Specialty: Anesthesiology, 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 50 year old female who sustained an industrial injury on August 12, 2014. The worker is being treated for: lumbar radiculopathy, right ankle pain joint, plantar fasciitis. Subjective: February 27, 2015, March 26, 2015, "no changes, constant pain, taking medications helps, walking increases the pain." September 21, 2015, reports lumbar spine and right foot pain; difficulty sleeping. Objective: February 27, 2015, March 26, 2015, "same"; lumbar spine with decreased sensation at the L5 right nerve distribution; positive SLR; tenderness at lumbar spine junction, and muscle spasm at bilateral lumbar muscles; limited range of motion due to pain. The right ankle showed tenderness at the Achilles and the calcaneus, and plantar fascia. September 21, 2015, walked with a definite limp on the right; could not walk on her heels due to pain; noted tenderness over the lumbosacral joint midline. There was note of a positive SLR while seated at 70 degrees, positive Lasegue's, right. Medications: March 26, 2015: Norco 5mg 325mg, Continue with Voltaren and a trial of Terocin lotion addressing pain and inflammation. September 21, 2015, noted Tylenol and Norco. February 27, 2015 reported recommending discontinuing Gabapentin; continue Voltaren and trial of Terocin lotion. Diagnostics: CT lumbar spine. Treatments: occupational therapy, full duty work February 06, 2015. On September 21, 2015 a request was made for CT of lumbar spine, lumbar epidural injection which were noncertified by Utilization Review on September 28, 2015.

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

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

### **CT Scan of Lumbar Spine: Overturned**

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004.

**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, CT (computed tomography).

**Decision rationale:** Per the ODG guidelines regarding CT: Not recommended except for indications below for CT. (Slebus, 1988) (Bigos, 1999) (ACR, 2000) (Airaksinen, 2006) (Chou, 2007) Magnetic resonance imaging has largely replaced computed tomography scanning in the noninvasive evaluation of patients with painful myelopathy because of superior soft tissue resolution and multiplanar capability. (Seidenwurm, 2000) The new ACP/APS guideline as compared to the old AHCPR guideline is more forceful about the need to avoid specialized diagnostic imaging such as computed tomography (CT) without a clear rationale for doing so. (Shekelle, 2008) A new meta-analysis of randomized trials finds no benefit to routine lumbar imaging (radiography, MRI, or CT) for low back pain without indications of serious underlying conditions, and recommends that clinicians should refrain from routine, immediate lumbar imaging in these patients. (Chou-Lancet, 2009) Primary care physicians are making a significant amount of inappropriate referrals for CT and MRI, according to new research published in the Journal of the American College of Radiology. There were high rates of inappropriate examinations for spinal CTs (53%), and for spinal MRIs (35%), including lumbar spine MRI for acute back pain without conservative therapy. (Lehnert, 2010) For suspected spine trauma (i.e., fractures, lumbar or cervical), thin-section CT examination with multiplanar reconstructed images may be recommended. Image software postprocessing capabilities of CT, including multiplanar reconstructions and 3-dimensional display (3D), further enhance the value of CT imaging for reconstructive trauma surgeons. (Daffner, 2009) If there is a contraindication to the magnetic resonance examination such as a cardiac pacemaker or severe claustrophobia, computed tomography myelography, preferably using spiral technology and multiplanar reconstruction is recommended. See the Neck Chapter. Indications for imaging: Computed tomography: Thoracic spine trauma: equivocal or positive plain films, no neurological deficit; Thoracic spine trauma: with neurological deficit; Lumbar spine trauma: trauma, neurological deficit; Lumbar spine trauma: seat belt (chance) fracture; Myelopathy (neurological deficit related to the spinal cord), traumatic; Myelopathy, infectious disease patient; Evaluate pars defect not identified on plain x-rays; Evaluate successful fusion if plain x-rays do not confirm fusion (Laasonen, 1989) Per note dated 9/21/15, decreased sensation at the right L5 nerve distribution. I respectfully disagree with the UR physician's assertion that CT scan is not indicated because NCS was previously performed. Per the medical records, it was noted that EMG/NCS was normal study. As the injured worker persists with neurological deficit, the request is medically necessary.

## **Lumbar Epidural Steroid Injection: 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:** Per the MTUS CPMTG epidural steroid injections are used 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 benefit. The criteria for the use of epidural steroid injections are as follows: 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. Per progress note dated 9/21/15, sensory exam revealed decreased sensation at the right L5 nerve distribution. Motor exam and reflexes were not documented. Imaging studies were not available for review. EMG/NCS was normal. Above- mentioned citation conveys radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Radiculopathy is defined as two of the following: weakness, sensation deficit, or diminished/absent reflexes associated with the relevant dermatome. These findings are not documented, so medical necessity is not affirmed. As the first criteria is not met, the request is not medically necessary. Furthermore, the request does not specify the operative level.