

<b>Case Number:</b>	CM15-0024621		
<b>Date Assigned:</b>	02/17/2015	<b>Date of Injury:</b>	10/20/2012
<b>Decision Date:</b>	03/31/2015	<b>UR Denial Date:</b>	01/22/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/09/2015

### 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: Preventive Medicine, Occupational Medicine

### 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 22 year old female who sustained an industrial injury to her lower back when she fell attempting to open a door on October 20, 2012. The injured worker was diagnosed with degenerative disc disease, lumbar spondylosis and lumbar stenosis. comorbid conditions include obesity (BMI 32.1). A magnetic resonance imaging (MRI) performed on June 19, 2014 demonstrated L4-L5 disk desiccation with posterior bulge with nerve root compromise, L5-S1 annular tear and lateral recess narrowing of the left S1 nerve root. According to the primary treating physician's progress report on January 2, 2015, the injured worker continues to experience low back pain with radiation into legs and numbness in legs. The injured worker's pain radiation to the lower extremities was noted as improved. The examination was documented as essentially normal with normal heel to toe walk without difficulty and normal motion. Pain scale rated as 4/10. Current medications consist of muscle relaxants for sleep, last used in Nov 2014. Treatment modalities consist of physical therapy 12 sessions completed, home exercise program, acupuncture therapy, chiropractic therapy, epidural steroid injection (ESI) and medication. Despite not being able to return from work she is able to go to the gym 4 days per week, play tennis, jog and walk. The treating physician requested authorization for Physical therapy twice a week for 6 weeks for the lumbar spine; Lumbar epidural steroid injection (ESI) at L5-S1; Facet injection lumbar spine, bilateral L4-L5 and L5-S1, QTY: 4. On January 22, 2015 the Utilization Review denied certification for Physical therapy twice a week for 6 weeks for the lumbar spine; Lumbar epidural steroid injection (ESI) at L5-S1; Facet injection lumbar spine, bilateral L4-L5 and L5-S1, QTY: 4. Citations used in the decision process were the Medical

Treatment Utilization Schedule (MTUS), Chronic Pain Guidelines, American College of Occupational and Environmental Medicine (ACOEM) and Official Disability Guidelines (ODG).

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

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

**Physical therapy 2xWk x 6Wks for the lumbar spine:** Overturned

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Preface, Physical Therapy

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 3 Initial Approaches to Treatment, Chapter 5 Cornerstones of Disability Prevention and Management, Chapter 12 Low Back Complaints Page(s): Chp 3 pg 48-9, Chp 5 pg 90, Chp 12 pg 299-301, 308-9, Chronic Pain Treatment Guidelines Physical Medicine Page(s): 98-9.

**Decision rationale:** Physical therapy can be active or passive. Passive therapy may be effective in the first few weeks after an injury but has not been shown to be effective after the period of the initial injury. Active therapy directed towards specific goals, done both in the Physical Therapist's office and at home is more likely to result in a return to functional activities. However, even with goal directed physical therapy for neuralgia, neuritis or radiculitis the resultant benefit should be apparent by the 10 sessions recommended in the MTUS. This patient has been to physical therapy for 12 sessions and has shown improvement in function. Further therapy, as per the MTUS, should allow for fading of treatment frequency from 3 visits per week to 1 or less, plus an active self-directed home physical medicine program. Medical necessity for continued therapy has been established but should be accomplished at the decreased frequency directed by the MTUS.

**Lumbar epidural steroid injection at L5-S1:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain, Epidural steroid injections (ESIs)

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 288, 309-10, Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs); Chronic Regional Pain Syndrome (sympathetic and epidural bl.

**Decision rationale:** The best medical evidence today for individuals with low back pain indicates that having the patient return to normal activities provides the best outcomes. Therapy should be guided, therefore, with modalities which will allow this outcome. Epidural steroid injections are an optional treatment for pain caused by nerve root inflammation as defined by pain in a specific dermatome pattern consistent with physical findings attributed to the same nerve root. As per the MTUS the present recommendations is for no more than 2 such injections, the second being done only if there is at least a partial response from the first

injection. Its effects usually will offer the patient short term relief of symptoms as they do not usually provide relief past 3 months, so other treatment modalities are required to rehabilitate the patient's functional capacity. The MTUS provides very specific criteria for use of this therapy. Specifically, the presence of a radiculopathy documented by examination and corroborated by imaging, and evidence that the patient is unresponsive to conservative treatment. In the documented care for this patient these criteria are not met. Even though the history is compatible with a possible radiculopathy, this is not supported by the exam, which is non-specific for a radiculopathy. Additionally, the patient has been responsive to conservative therapy and is very functional in that she is able to play tennis and jog. Thus, the patient does not meet the criteria for this requested therapy. Medical necessity for this procedure has not been established.

**Facet injection lumbar spine, bilateral L4-L5 and L5-S1, QTY: 4:** Overturned

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, 309. Decision based on Non-MTUS Citation American Society of Interventional Pain Physicians: Comprehensive evidence-based guidelines for interventional techniques in chronic spinal pain. Part II: guidance and recommendations Source: <http://www.guideline.gov/content.aspx?id=45379#Section420>

**Decision rationale:** Lumbar facet injections are an option in the treatment of pain caused by facet inflammation. The ACOEM guidelines point out its use is primarily of diagnostic benefit as there is inadequate evidence-based support for its use therapeutically. The American Society of Interventional Pain Physicians also notes good evidence to support its use as a diagnostic modality but note only fair evidence to support its therapeutic use. However, it only recommends the therapeutic use of facet injections for use after the appropriate diagnosis with controlled diagnostic lumbar facet joint blocks. The request for this procedure does not differentiate whether it is for diagnostic or therapeutic benefit. Medical necessity for the therapeutic use of this procedure has not been established but it would be appropriate for diagnostic purpose.