

<b>Case Number:</b>	CM15-0043984		
<b>Date Assigned:</b>	03/13/2015	<b>Date of Injury:</b>	02/22/1998
<b>Decision Date:</b>	04/22/2015	<b>UR Denial Date:</b>	02/26/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	03/09/2015

### 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: Pennsylvania

Certification(s)/Specialty: Internal 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 50 year old female who sustained an industrial injury on February 22, 1998. She reported mid and low back pain. The injured worker was diagnosed as having herniated discs of the thoracic spine, thoracic spondylosis, chronic pain syndrome, facet arthropathy of the thoracic spine and compression fracture of the thoracic vertebra. Treatment and evaluation to date has included diagnostic studies, home exercise program, nerve stimulator placement, medications and work restrictions. The injured worker reported decreased pain with the stimulator. Currently, the injured worker complains of chronic mid and low back pain. It was noted she required the use of daily pain medications to maintain the ability to perform activities of daily living. Evaluation on October 24, 2014, revealed intractable mid back pain. The injured worker denied weakness or paresthesias. The plan was to continue medications and a home exercise plan. Examination showed tenderness and limited range of motion of the thoracic area, negative straight leg raising, diffuse tenderness over the lower lumbar area, normal gait, normal strength, sensation, and reflexes in the upper and lower extremities. Evaluation on February 18, 2015, revealed continued pain. The physician noted that the injured worker had increased low back pain, spasms, stiffness, and radiculopathy in both lower extremities. Review of systems was again negative for weakness or paresthesias. Examination was unchanged and continued to show normal strength, sensation, and reflexes in the upper and lower extremities. An epidural steroid injection and physical therapy were discussed. On 2/26/15, Utilization Review (UR) non-certified requests for caudal ESI (epidural steroid injection), anesthesia with x-ray, fluoroscopic guidance, and physical therapy X 8; citing the MTUS.

## IMR ISSUES, DECISIONS AND RATIONALES

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

**Caudal epidural:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines epidural steroid injections Page(s): 46.

**Decision rationale:** The MTUS, chronic pain section, page 46 describes the criteria for epidural steroid injections. Epidural injections are a possible option when there is radicular pain caused by a radiculopathy documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. There must be documentation of failure of conservative treatment such as exercises, physical methods, non-steroidal anti-inflammatory agents, and muscle relaxants. An epidural steroid injection must be at a specific side and level. Although the treating physician notes that the injured worker had "radiculopathy," there are insufficient clinical findings of radiculopathy, such as dermatomal sensory loss or motor deficits correlating with a specific lesion identified by objective testing. No imaging studies or electrodiagnostic testing was submitted. No level of injection was specified. Due to lack of objective findings of radiculopathy, and lack of a sufficiently specific prescription including side and level to be injected, the request for caudal epidural steroid injection is not medically necessary.

**Anesthesia with X-ray:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation associated service.

**Decision rationale:** The request for anesthesia with x-ray is associated with the request for epidural steroid injection. The caudal epidural steroid injection has been determined to be not medically necessary. As such, the associated service of anesthesia with x-ray is not medically necessary.

**Fluoroscopic guidance:** Upheld

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

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation associated service.

**Decision rationale:** The request for fluoroscopic guidance is associated with the request for epidural steroid injection. The caudal epidural steroid injection has been determined to be not medically necessary. As such, the associated service of fluoroscopic guidance is not medically necessary.

**PT 8 sessions, 2x a week for 4 weeks:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines physical medicine Page(s): 98-99. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) pain chapter: physical medicine treatment.

**Decision rationale:** Physical medicine is recommended by the MTUS with a focus on active treatment modalities to restore flexibility, strength, endurance, function, and range of motion, and to alleviate discomfort. The records do not contain a sufficient prescription from the treating physician, which must contain diagnosis, duration, frequency, and treatment modalities, at a minimum. Reliance on passive care is not recommended. The physical medication prescription is not sufficiently specific, as no body part to be treated was specified, and does not adequately focus on functional improvement. No functional goals were discussed. There was no documentation of prior physical therapy in the records submitted, although a home exercise program was discussed. The number of sessions recommended by the guidelines is contingent on the body part to be treated, which was not stated in this case. Due to lack of a sufficiently specific prescription, the request for PT 8 sessions, 2x a week for 4 weeks is not medically necessary.