Case Number:	CM15-0089205		
Date Assigned:	05/13/2015	**Date of Injury:**	11/18/2013
Decision Date:	06/18/2015	**UR Denial Date:**	04/21/2015
Priority:	Standard	**Application Received:**	05/08/2015

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, Texas, New Mexico
Certification(s)/Specialty: Anesthesiology

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 61-year-old male, who sustained an industrial injury on 11/18/13. The injured worker was diagnosed as having cervical spine sprain/strain, cervical spine HNP, cervical radiculopathy, right shoulder sprain/strain, right shoulder internal derangement, right shoulder RCT, lumbar spine sprain/strain, lumbar spine HNP, lumbar radiculopathy, anxiety disorder, mood disorder, sleep disorder, stress and hypertension. Treatment to date has included oral medications, transdermal medications, physical therapy, shockwave therapy and chiropractic treatment. (MRI) magnetic resonance imaging of right shoulder was performed on 12/8/14 and revealed full thickness tear of anterior fibers of the supraspinatus tendon with 9mm of medial retraction, interstitial partial thickness tear of infraspinatus tendon area, subscapularis tendinosis, glenohumeral joint effusion and fluid within the subacromial /sub deltoid space and acromioclavicular joint hypertrophy is noted. (MRI) magnetic resonance imaging of cervical spine was performed on 12/8/14 and revealed C3-4 broad based disc herniation, C4-5 broad based disc herniation, C5-6 posterior annular tear/fissure and C6-7 central focal disc protrusion that abuts the thecal sac. (MRI) magnetic resonance imaging of lumbar spine performed on 12/8/14 revealed L4-5 board based disc protrusion that abuts the thecal sac, L5-S1 left paracentral disc herniation that compresses the left L5 and S1 nerve roots and posterior anular tear/fissure. Currently, the injured worker complains of burning, radicular neck pain described as constant, moderate to severe rated 7/10 and associated with numbness and tingling of the bilateral upper extremities; burning right shoulder pain rated 7/10 described as constant, moderate to severe and burning, radicular low back pain rated 7/10 described as constant,

moderate to severe and associated with numbness and tingling of the bilateral lower extremities. Physical exam noted tenderness to palpation at the occiputs, trapezius, sternocleidomastoid and levator scapula muscles with restricted range of motion, tenderness to palpation at the AC joint, subacromial space, levator scapula, supraspinatus and trapezius muscles with restricted range of motion and lumbar spine exam noted tenderness to palpation of paraspinal muscles and over the lumbosacral junction with trigger point noted at the PSOS and sciatic notch tenderness with restricted range of motion of lumbar spine. A request for authorization was submitted for epidural steroid injection and post-operative physical therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

L4-5 Lumbar Epidural Steroid Injection, per 03/31/2015: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs) Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic.

Decision rationale: According to MTUS guidelines, epidural steroid injections are an option for the treatment of low back pain with radiculopathy. Current recommendations are for no more than two epidural steroid injections. This patient does have subjective (reported radicular pain) and objective evidence of radiculopathy. There are documented MRI findings from 12/08/2014 consistent with a diagnosis of lumbar radiculopathy. The MTUS guidelines clearly state there must be documented evidence of radiculopathy both by physical examination and imaging studies or electrodiagnostic testing. According to the ODG, diagnostic epidural steroid injections are also recommended to help determine pain generators when diagnostic imaging is ambiguous or inconclusive. Epidural steroid injections should only be performed under fluoroscopic guidance and repeated injections should be based on continued documented evidence of improvement including at least 50% pain relief and a six to eight week reduction in the use of medication. In this case, the above listed issue IS considered medically necessary.

Post-Operative Physical Therapy, 2 x 6 weeks, Lumbar Spine, per 03/31/2015: Overturned

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) Low Back - Thoracic & Lumbar (Acute & Chronic) Physical Therapy.

Decision rationale: According to the MTUS Guidelines exercise and active type, physical therapy is recommended; however, there is no recommendation for any particular exercise program or regimen over any other program. Active therapy helps to restore function and can

help alleviate discomfort. It also requires internal individual patient effort. For radiculitis the MTUS guidelines recommends from 1 to 3 visits per week. The ODG recommends physical therapy post epidural steroid injections. Although there is only a small amount of evidence to support physical therapy after epidural steroid injection it can be utilized to decrease pain and inflammation and to help emphasize a home exercise program. Therefore, the above listed issue IS considered medically necessary.