MAXIMUS Federal Services

Case Number:	CM15-0116230		
Date Assigned:	06/24/2015	Date of Injury:	01/05/2011
Decision Date:	08/20/2015	UR Denial Date:	05/19/2015
Priority:	Standard	Application Received:	06/16/2015

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 52 year old male who sustained a work related injury January 5, 2011. Past history included right L5-S1 microdiscectomy 12/2/2011, s/p L5-S1 posterior lumbar interbody fusion May 2012. According to a treating physician's progress report, dated May 7, 2015, the injured worker presented with low back pain, intermittent left posterior thigh pain and left shoulder impingement syndrome. He reports having gained 20 pounds, due to inactivity secondary to pain. Physical examination revealed he is able to rise out of a chair with ease, his gait is brisk with good coordination, and his posture and station are neutral. Shoulder examination revealed positive impingement sign; Neer's and Hawkins. External rotation limited to pain with mild tenderness over the AC (acromioclavicular) joints. Sensation to touch is intact throughout the bilateral lower extremities and straight leg raise is negative bilaterally. Diagnoses are recurrent far right lateral disc herniation L5-S1; left shoulder impingement syndrome, possible rotator cuff tear. Treatment plan included a request for authorization for bilateral L4-5 TF (transforaminal) ESI (epidural steroid injection) with bilateral L4-5 medial branch blocks, x- ray left shoulder, 3 views, MRI without contrast, left shoulder, and a weight loss program.

IMR ISSUES, DECISIONS AND RATIONALES

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

Steroid bilateral L4-L5 TF ESI with bilateral L4-L5 medial branch blocks: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ESI Page(s): 46-47. Decision based on Non-MTUS Citation Low Back - Lumbar & Thoracic (Acute & Chronic) Chapter, Facet joint diagnostic blocks (injections).

Decision rationale: This patient is presents with low back pain, intermittent left posterior thigh pain and left shoulder impingement syndrome. The current request is for Steroid bilateral L4-L5 TF ESI with bilateral L4-L5 medial branch blocks. Treatment history included lumbar surgical intervention 2011 and 2012, S1 selective nerve root injections, LESI 2013, medications, and physical therapy. The patient is temporary totally disabled. MTUS Chronic Pain Treatment Guidelines, section on "Epidural steroid injections (ESIs)" page 46 states these are "Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy)." The MTUS Criteria for the use of Epidural steroid injections states: "Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing." In addition, MTUS states that the patient must be "Initially unresponsive to conservative treatment (exercise, physical methods, NSAIDs and muscle relaxants)." For repeat ESI, MTUS states, "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." ODG Guidelines, Low Back - Lumbar & Thoracic (Acute & Chronic) Chapter, Facet joint diagnostic blocks (injections) Section states: "For Facet joint diagnostic blocks for both facet joint and Dorsal Median Branches: Limited to patients with low-back pain that is non-radicular and at no more than two levels bilaterally." "... there should be no evidence of radicular pain, spinal stenosis, or previous fusion," and "if successful (initial pain relief of 70%, plus pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to medial branch diagnostic block and subsequent neurotomy (if the medial branch block is positive)." MRI of the lumbar spine from 01/08/15 revealed good position of implants without evidence of loosening; no change compared to prior imaging, L4-5 with slight progression of DDD. CT scan of the lumbar spine from 09/26/14 revealed incomplete bridging across L5-S1 disk space, and L4-5 vacuum disk with moderate stenosis. According to progress report 05/07/15, the patient complains of low back pain radiating down the right leg. Examination revealed patient is able to rise from chair with ease, brisk gait with good coordination, 5/5 strength through the lower extremities, sensation is intact, and SLR is negative. The treater recommended "serial selective injections for diagnostic and therapeutic purposes: 1. Bilateral L5-S1 hardware block; 2. Bilateral L4-L5 TF ESI with bilateral L4-L5 medial branch blocks." The hardware block was subsequently approved by UR letter dated 05/19/15.First and foremost, this treater is requesting two injections concurrently that contradict each other. For this patient, the request for L4-5 bilateral TF ESI cannot be substantiated as physical examination findings do not support the patient's radiating symptoms. MTUS states "Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing." In fact, all examinations finding pertaining to the lower back and lower extremities were negative. In regard to the requested L4-L5 bilateral medial branch block, ODG states that MBBs may be

considered when there is no radicular pain and no spinal stenosis. This patient complains of leg pain and MRI dated 01/08/15 documents "moderate stenosis" at L4-L5. This patient does not meet the criteria set forth by MTUS for either injections. This request is not medically necessary.

X-ray three views, left shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder chapter, X-rays.

Decision rationale: This patient is presents with low back pain, intermittent left posterior thigh pain and left shoulder impingement syndrome. The current request is for x-ray three views, left shoulder. Treatment history included lumbar surgical intervention 2011 and 2012, S1 selective nerve root injections, LESI 2013, medications, and physical therapy. The patient is temporary totally disabled. ODG Guidelines has the following regarding x-rays under its shoulder chapter, "The acutely traumatized shoulder should be imaged with plain films that are orthogonal to each other. Indications are for acute trauma, to rule out fracture/dislocation, questionable bursitis, or blood calcium." X-rays of the shoulder are generally reserved for acute trauma to rule out fracture/dislocation, questionable bursitis, or blood calcium. In this case, the patient presents with a long history of left shoulder complaints. In addition, although an x-ray report was not found in the medical reports, the UR letter states that the patient has had x-rays of the left shoulder in October 2014. The results of the x-rays were not discussed. This request is not medically necessary.

MRI without contrast, left shoulder: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 9 Shoulder Complaints Page(s): 207-208. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Shoulder (Acute & Chronic) Chapter, under Magnetic resonance imaging.

Decision rationale: This patient is presents with low back pain, intermittent left posterior thigh pain and left shoulder impingement syndrome. The current request is for MRI without contrast, left shoulder. Treatment history included lumbar surgical intervention 2011 and 2012, S1 selective nerve root injections, LESI 2013, medications, and physical therapy. The patient is temporary totally disabled. ACOEM Guidelines has the following regarding shoulder MRI on pages 207 and 208, routine testing (laboratory test, plain-film radiographs of the shoulder) and more specialized imaging studies are not recommended during the first 6 weeks of activity limitation due to shoulder symptoms, except when a red flag noted on history or examination raises suspicion of serious shoulder condition or referred pain. ODG-TWC, Shoulder (Acute &

Chronic) Chapter, under Magnetic resonance imaging (MRI) states: "Indications for imaging -- Magnetic resonance imaging (MRI): Acute shoulder trauma, suspect rotator cuff tear/impingement; over age 40; normal plain radiographs; Subacute shoulder pain, suspect instability/labral tear; Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology." (Mays, 2008) MRI of the left shoulder from 10/03/14 noted moderate arthrosis of the acromioclavicular joint, there is acromion type 1 bursal fluid, at least moderate tendinosis of the supraspinatus and infraspinatus tendon. There is rotator interval synovitis, minor sub labral and anterior labral partial SLAP tear and moderate intra-articular biceps tendinosis. This patient had a meniscus repair back in 1987. The treater states that the patient subsequently developed rotator cuff tendonitis. His symptoms have been managed with ice, PT and medication. Most recent physical examination on 05/07/15 revealed positive impingement, Neer's and Hawken's sign. External rotation is limited to pain with mild tenderness over the AC joints. The treater recommended an MRI to assess chronic shoulder pain and evaluate rotator cuff tear. ODG guidelines support MRI of the shoulder if conservative measures have failed and rotator cuff or labral tear is suspected. However, there are no new injuries, change in clinical status, significant changes in examination, new location of symptoms, or red flags since the 10/03/14 MRI warrant repeat imaging. Therefore, this request is not medically necessary.

Weight loss program: 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 Exercise Page(s): 46-47. Decision based on Non-MTUS Citation AETNA website was referenced: www.aetna.com/cpb/medical/data/1_99/0039.html www.lindora.com/lhc-riteaid.aspx.

Decision rationale: This patient is presents with low back pain, intermittent left posterior thigh pain and left shoulder impingement syndrome. The current request is for Weight loss program. Treatment history included lumbar surgical intervention 2011 and 2012, S1 selective nerve root injections, LESI 2013, medications, and physical therapy. The patient is temporary totally disabled. MTUS Guidelines page 46 and 47 recommends exercise, but states that there is no sufficient evidence to support the recommendation of any particular exercise regimen over any other exercise regimen. MTUS, ODG, nor ACOEM are silent on weight loss programs. Therefore, the AETNA website was referenced: www.aetna.com/cpb/medical/data/1_99/0039.html.AETNA allows "medically supervised" weight loss program only if the patient has failed caloric restriction and physical activity modifications. www.lindora.com/lhc-riteaid.aspx states that the [redacted] is a medically supervised weight loss program. According to progress report 05/07/15, the patient complains of low back pain radiating down the right leg. Examination revealed patient is able to rise from chair with ease, brisk gait with good coordination, 5/5 strength through the lower extremities, sensation is intact, and SLR is negative. The treater recommended a weight loss program as the patient has gained over 20 pounds due to inactivity secondary to pain. In this case, there is no mention of physical activity modifications, trialed and failed caloric restrictions, nor failure of

home exercise program. Furthermore, there is no end-point to the request, as the duration of the program is indeterminate. Therefore, the request is not medically necessary.