

<b>Case Number:</b>	CM15-0129329		
<b>Date Assigned:</b>	07/15/2015	<b>Date of Injury:</b>	03/24/2010
<b>Decision Date:</b>	08/24/2015	<b>UR Denial Date:</b>	06/22/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/03/2015

### 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, North Carolina  
 Certification(s)/Specialty: Family Practice

### 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 51 year old male who sustained an industrial/work injury on 3/24/10. He reported an initial complaint of pain in back, shoulder, hip, and neck. The injured worker was diagnosed as having lumbosacral neuritis, rotator cuff syndrome, osteoarthritis of shoulder, cervical disc displacement, enthesopathy of hip, spinal stenosis, and superior glenoid labrum lesion. Treatment to date includes medication, chiropractic care, acupuncture, physical therapy, injections, cane, transcutaneous electrical nerve stimulation (TENS) unit, and diagnostics. MRI results were reported on 9/25/11 and 12/20/13 reveals degenerative disk disease and facet arthropathy with retrolisthesis at L5-S1. CT scan results reported on 11/23/10 note minimal age-related degenerative changes. X-ray results reported on 1/18/11 note degenerative disc disease. EMG/NCV (electromyography and nerve conduction velocity) test was performed on 10/30/13 that demonstrates bilateral S1 radiculopathy. Currently, the injured worker complained of neck, mid and low back pain described as aching and stabbing, rated 7-8/10, and pulsing symptoms into the lower extremities. The neck feels stiff with aching pain. A cane is used for ambulation. Per the primary physician's report (PR-2) on 5/20/15, exam reported reflexes normal except hyperflexic lower extremities symmetrically, positive Bowstring sign on right, limited hip extension, 5-/5 right leg extension, improper lumbar extension, positive Faber's, Gaenslen's, S1 thigh thrust test, Hawkin's, impingement, empty can test, and Ober's test on right. Current plan of care included medication, epidural injection for right L4, aquatic therapy, continuing transcutaneous electrical nerve stimulation (TENS) unit and follow up. The requested treatments

include Transforaminal Epidural Steroid Injection at Right L4 for Lumbar Radiculopathy, Pharmacy Purchase of Norco 7.5/325mg, and Aquatic Therapy.

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

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

#### **Transforaminal Epidural Steroid Injection at Right L4 for Lumbar Radiculopathy:**

Upheld

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

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

**Decision rationale:** CA MTUS Guidelines require at least 50% relief of pain for at least 6-8 weeks in order for a second ESI to be recommended. In this case, the last ESI provided good relief of 70-80%, however the duration was only 2.5 weeks. Thus base on the guidelines, criteria are not satisfied for a repeat ESI. Thus the request is not medically necessary.

#### **Pharmacy Purchase of Norco 7.5/325mg #120:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Opioids for chronic pain Page(s): 78-80.

**Decision rationale:** MTUS Guidelines recommend continued use of opioids for treatment of moderate to severe pain with documented evidence of functional benefit. Base on the information submitted, this patient has not experienced any functional benefit from the chronic usage of Norco. Therefore, the request is not medically necessary.

#### **Aquatic Therapy 2 times a week for 8 weeks:** Upheld

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

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic therapy Page(s): 22.

**Decision rationale:** MTUS states that aquatic therapy (AT) is recommended as an optional form of exercise therapy, when available, as an alternative to land-based therapy. AT minimizes the effects of gravity and is recommended when reduced weight-bearing is desirable, especially in cases of extreme obesity. The AT appears to be indicated for this patient, however the request of 16 sessions is excessive. Thus the request is deemed not medically necessary at this time.