

<b>Case Number:</b>	CM15-0129514		
<b>Date Assigned:</b>	07/16/2015	<b>Date of Injury:</b>	12/01/2012
<b>Decision Date:</b>	08/11/2015	<b>UR Denial Date:</b>	06/25/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	07/06/2015

### 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: Maryland

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular 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 54 year old male, who sustained an industrial injury on 12/01/2012. The medical records submitted did not include clear documentation of the initial injury. Diagnoses include lumbar facet syndrome, lumbar degenerative disc disease, low back pain and lumbar sprain/strain. Treatments to date include activity modification, medication therapy, physical therapy, lumbar medial branch nerve blocks, radiofrequency ablation, and therapeutic injections. Currently, he complained of low back pain with radiation to lower extremities. Pain was rated 6/10 VAS with medication and 9/10 VAS without medication. On 6/19/15, the physical examination documented limited lumbar range of motion and tenderness. The straight leg raise test and lumbar facet loading tests were positive bilaterally. There was decreased sensation on the right lower extremity. The plan of care included Transforaminal Epidural Steroid Injection (TFESI) at right L3 and L4; and a request to authorize a repeated MRI of the lumbar spine.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**1 right TFESI L3, L4: Upheld**

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

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

**Decision rationale:** 1 right TFESI L3, L4 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The MTUS states that 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. The documentation dated 12/9/14 states that the patient received multiple lumbar epidural steroid injections which provided 50% relief for 2 months and multiple transforaminal epidural steroid injections which provided 80% relief for 3 weeks. The documentation is not clear that the patient has also had an associated reduction of medication use for six to eight weeks post injections therefore this request is not medically necessary.

**1 repeat MRI of lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back - Lumbar & Thoracic (Acute & Chronic), MRIs (magnetic resonance imaging).

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303,304. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back MRIs (magnetic resonance imaging).

**Decision rationale:** 1 repeat MRI of lumbar spine is not medically necessary per the MTUS and the ODG Guidelines. The documentation indicates that the patient had a lumbar MRI on 2/23/15. MRI of the lumbar spine is not medically necessary per the MTUS and the ODG Guidelines. The MTUS recommends imaging studies be reserved for cases in which surgery is considered, or there is a red-flag diagnosis. The guidelines state that unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment. The ODG recommends a lumbar MRI when there is a suspected red flag condition such as cancer or infection or when there is a progressive neurologic deficit. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation). The documentation submitted does not reveal progressive neurologic deficits, or a red flag diagnoses. The request for a repeat MRI of the lumbar spine is not medically necessary.