

Case Number:	CM15-0172645		
Date Assigned:	09/14/2015	Date of Injury:	10/02/2013
Decision Date:	10/14/2015	UR Denial Date:	08/05/2015
Priority:	Standard	Application Received:	09/02/2015

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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 57 year old male, who sustained an industrial-work injury on 10-2-13. He reported initial complaints of mid and lower back pain. The injured worker was diagnosed as having bilateral lower extremity dysesthesias. Treatment to date has included medication, activity modification, trigger point injections, physical therapy, and work conditioning. MRI results were reported on 6-3-15 of the thoracic spine that demonstrated moderate canal stenosis at T11-12 secondary to a 2 mm disc bulge with a superimposed 2 mm central and right paracentral protrusion in associated with facet degenerative disease, large right anterior osteophytes at T11-12, moderate to severe bilateral neuroforaminal narrowing at C7-T1 and mild multilevel neuroforaminal narrowing of the thoracic spine on the basis of facet degenerative disease and mild compression deformities and multilevel Schmorl's nodes. EMG-NCV (electromyography and nerve conduction velocity test) were reported on 7-17-15. X-rays were reported on 7-17-15 that demonstrated spondylitic changes without any evidence of fracture or instability. Currently, the injured worker complains of mid to low back pain with radiation to bilateral legs. There was burning pain in the bilateral thighs and 'pins and needles' sensation. Per the primary physician's progress report (PR-2) on 7-17-15, exam noted mild decline in balance, fairly normal tandem gait, slightly decreased sensation to light touch in the anterior thighs, subtle hip flexor weakness bilaterally, subtle hip flexor weakness bilaterally. Current plan of care includes ESI (epidural steroid injection). The Request for Authorization date was 7-17-15 and requested service included thoracic spine Epidural Steroid Injection. The Utilization Review on 8-5-15 denied the request for lack of documentation regarding radiculopathy per physical

findings or corroborated by imaging studies or electrodiagnostic testing per CA MTUS (California Medical Treatment Utilization Schedule), Chronic Pain Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Thoracic Spine Epidural Steroid Injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

Decision rationale: The claimant sustained a work injury in October 2013 and is being treated for made and low back pain with radiating lower extremity symptoms beginning after a cane up a heavy bag of concrete. When seen, there had been a mild decline in balance. He was having burning thigh pain bilaterally with pins and needles sensation. Physical examination findings included decreased lower extremity sensation with hip flexor weakness with mildly increased patellar reflexes. Imaging results were reviewed including an MRI of the thoracic spine showing a right lateralized T11/12 disc protrusion with moderate canal stenosis. The impression references lower extremity dysesthesias possibly related to thoracic stenosis. An epidural injection was requested for diagnostic and therapeutic purposes to determine whether he might be a candidate for a thoracic level laminectomy. Criteria for the use of epidural steroid injections include radicular pain, defined as pain in dermatomal distribution with findings of radiculopathy documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. In this case, there are no thoracic level radicular complaints such as pain in a segmental distribution or right lateralized findings that would correlate with the reported imaging findings. There was no examination of the thoracic dermatomes or an evaluation of abdominal muscle strength, positive Beevor's sign, or abnormal abdominal reflex response that would support a diagnosis of thoracic level radiculopathy or myelopathy. A thoracic epidural steroid injection is not considered medically necessary.