

<b>Case Number:</b>	CM15-0177903		
<b>Date Assigned:</b>	09/18/2015	<b>Date of Injury:</b>	03/10/1999
<b>Decision Date:</b>	12/01/2015	<b>UR Denial Date:</b>	09/03/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	09/09/2015

### 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, 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 67 year old male, who sustained an industrial injury on 03-10-1999. He has reported subsequent low back and left knee pain and was diagnosed with post-laminectomy syndrome of the lumbar region, degenerative disc disease of the lumbar spine with myelopathy and thoracic and lumbosacral neuritis and radiculitis. CT of the lumbar spine dated 07-25-2015 showed central canal stenosis of L2-L4, slightly more severe at L3-L4, similar changes at L1-L2 without resultant stenosis and mild foraminal stenosis. Treatment to date has included oral pain medication, lumbar epidural injection, physical therapy of the knee, treatment by a psychologist and L4-L5, L5-S1 back fusion in 2002. Documentation shows that the injured worker had a caudal epidural steroid injection performed on 06-17-2015. The physician noted that the injured worker had obtained a favorable functional response epidural steroid injection with greater than 70% relief. In a progress note dated 08-13-2015, the injured worker reported low back pain with radiation to the front of the knees and bilateral lower extremity weakness. The physician noted that the injured worker had attempted home exercise which increased pain and that the pain was affecting activities of daily living. Objective examination findings were notable for pain with flexion and extension of the lumbosacral spine, tenderness to palpation of the paraspinals, forward flexion of 40 degrees, hyperextension of 5 degrees, bilateral lateral bend at 25 degrees, an antalgic gait and positive sitting straight leg raise on the right. Work status was documented as temporarily totally disabled. An EMG on 2/11/2015 showed chronic Right LE radiculopathy. A CT scan of the lumbar spine was done on 7/21/2015. A request for authorization of physical therapy x 12 visits for the lumbar spine, x-ray of the lumbar spine, MRI of the lumbar spine and caudal injection x 1 was submitted. As per the utilization review on 09-03-2015, the requests for physical therapy x 12 visits for the lumbar spine, x-ray of the lumbar spine, MRI of the lumbar spine and caudal injection x 1 were non-certified.

## IMR ISSUES, DECISIONS AND RATIONALES

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

### **Physical Therapy x12 visits for the lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Physical Therapy Guidelines.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods, and Chronic Pain Medical Treatment 2009, Section(s): Physical Medicine. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Physical Therapy.

**Decision rationale:** Regarding the request for additional physical therapy, Chronic Pain Medical Treatment Guidelines recommend a short course of active therapy with continuation of active therapies at home as an extension of the treatment process in order to maintain improvement levels. ODG has more specific criteria for the ongoing use of physical therapy. ODG recommends a trial of physical therapy. If the trial of physical therapy results in objective functional improvement, as well as ongoing objective treatment goals, then additional therapy may be considered. Within the documentation available for review, there is documentation of completion of prior PT sessions, but there is no documentation of specific objective functional improvement with the previous sessions and remaining deficits that cannot be addressed within the context of an independent home exercise program, yet are expected to improve with formal supervised therapy. Furthermore, it is unclear how many therapy sessions the patient has already undergone making it impossible to determine if the patient has exceeded the maximum number recommended by guidelines for their diagnosis. In light of the above issues, the currently requested additional physical therapy is not medically necessary.

### **X-ray of the lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Indications for plain X-rays.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Diagnostic Criteria, Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Radiography (X-rays).

**Decision rationale:** Regarding request for lumbar spine x-ray, Occupational Medicine Practice Guidelines state that x-rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology even if the pain has persisted for at least 6

weeks. However, it may be appropriate when the physician believes it would aid in patient management. Guidelines go on to state that subsequent imaging should be based on new symptoms or a change in current symptoms. Within the documentation available for review, it is clear the patient has recently undergone a lumbar CT scan. There is no statement indicating how the patient's symptoms or findings have changed since the time of the most recent imaging. Additionally, the requesting physician has not stated how his medical decision-making will be changed based upon the outcome of the currently requested lumbar x-ray. In the absence of clarity regarding those issues, the currently requested lumbar x-ray is not medically necessary.

**MRI of the lumbar spine:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Indications for magnetic resonance imaging.

**MAXIMUS guideline:** Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, MRIs (magnetic resonance imaging).

**Decision rationale:** Regarding the request for lumbar MRI, Occupational Medicine Practice 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 and would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. ODG states that MRIs are recommended for uncomplicated low back pain with radiculopathy after at least one month of conservative therapy. Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology. Within the documentation available for review, there is no identification of any objective findings that identify specific nerve compromise on the neurologic exam. Additionally, there is no statement indicating what medical decision-making will be based upon the outcome of the currently requested MRI. Furthermore, there is no documentation indicating how the patient's subjective complaints and objective findings have changed since the time of the most recent CT scan of the lumbar spine. In the absence of clarity regarding those issues, the currently requested lumbar MRI is not medically necessary.

**Caudal injection x1:** 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:** Regarding the request for repeat caudal epidural steroid injection, Chronic Pain Medical Treatment Guidelines state that epidural injections are recommended as an option for treatment of radicular pain, defined as pain in dermatomal distribution with corroborative

findings of radiculopathy, and failure of conservative treatment. Guidelines recommend that no more than one interlaminar level, or to transforaminal levels, should be injected at one session. Regarding repeat epidural injections, guidelines state that 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. Within the documentation available for review, there is no indication of pain relief with associated reduction of medication use for 6 to 8 weeks as well as specific functional improvement from previous epidural injections. As such, the currently requested repeat caudal epidural steroid injection is not medically necessary.