

<b>Case Number:</b>	CM15-0022944		
<b>Date Assigned:</b>	02/12/2015	<b>Date of Injury:</b>	03/24/2005
<b>Decision Date:</b>	04/01/2015	<b>UR Denial Date:</b>	01/15/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	02/06/2015

### 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: New York

Certification(s)/Specialty: Internal 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:

This male injured worker sustained an industrial injury on March 24, 2005. The mechanism of injury is unknown. The diagnoses have included lumbago, mood disorder in conditions classified elsewhere, postlaminectomy syndrome of lumbar region, thoracic/lumbosacral neuritis/radiculitis and other symptoms referable to back. Treatment to date has included diagnostic studies, medications and home exercises. Currently, the injured worker complains of intense pain in the lower back with radiation to his anterior thigh, calf and dorsal aspect of his foot along with associated numbness, tingling and slight weakness. The pain was rated as an 8 on a 1-10 pain scale. Notes stated that despite treatment, the injured worker still suffers from progress low back radicular pain affecting his mobility and functionality. On January 15, 2015, Utilization Review non-certified a sleep study, x-ray series of the lumbar spine with lateral flexion and extension views, referral to psychologist and caudal epidural with catheter, noting the CA MTUS, ACOEM and Official Disability Guidelines. On February 6, 2015, the injured worker submitted an application for Independent Medical Review for review of sleep study, x-ray series of the lumbar spine with lateral flexion and extension views, referral to psychologist and caudal epidural with catheter.

### IMR ISSUES, DECISIONS AND RATIONALES

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

### **Sleep Study: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG-TWC, Pain Procedure Summary.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medscape Internal Medicine 2014: Indications for a Sleep Study.

**Decision rationale:** The term central sleep apnea encompasses a heterogeneous group of sleep-related breathing disorders in which respiratory effort is diminished or absent in an intermittent or cyclical fashion during sleep. [1] In most cases, central sleep apnea is associated with obstructive sleep apnea syndromes or is caused by an underlying medical condition, recent ascent to high altitude, or narcotic use. Primary central sleep apnea is a rare condition, the etiology of which is not entirely understood. During Polysomnography (PSG), a central apneic event is conventionally defined as cessation of airflow for 10 seconds or longer without an identifiable respiratory effort. In contrast, an obstructive apneic event has a discernible ventilatory effort during the period of airflow cessation. In this case the claimant has been diagnosed with depression and anxiety. There is no documentation of a history of excessive daytime somnolence, morning headaches, cataplexy, excessive snoring, intellectual deterioration, personality change or insomnia lasting more than six months. Medical necessity for the requested study is not established. The requested study is not medically necessary.

### **X-Ray Series of the Lumbar Spine With Lateral Flexion and Extension Views: Upheld**

**Claims Administrator guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303.

**MAXIMUS guideline:** The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines: Low Backpage 303.

**Decision rationale:** According to ODG lumbar spine films with lateral flexion and extension views are indicated prior to lumbar fusion. Per the documentation the claimant had the insertion of spacers at L3-L4 and L4-L5 on 1/14/09 and had lumbar spine films with lateral flexion and extension views which demonstrated instability. There is no specific indication for repeat films at this time. Medical necessity for the requested item is not established. The requested item is not medically necessary.

### **Referral to Psychologist: Upheld**

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

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 15 Stress Related Conditions Page(s): 127, Chronic Pain Treatment Guidelines Psychological Evaluations Page(s): 100-101.

**Decision rationale:** According to ODG, referral to a specialist is indicated if a diagnosis is uncertain or extremely complex, or when the plan or course of care may benefit from additional expertise. CA MTUS states psychological evaluations are recommended to determine if certain psychosocial interventions are indicated for treatment. The documentation indicates the claimant had a previous psychological evaluation and has been diagnosed with depression and anxiety. There is no documentation indicating whether he received previous treatment in the past. Medical necessity for the requested service is not established. The requested service is not medically necessary.

**Caudal Epidural With Catheter:** Upheld

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

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

**Decision rationale:** The review has indicated that the claimant has radiculopathy but no neurologic deficits on exam. Per California MTUS 2009 Guidelines epidural steroid injections are recommended as an option for treatment of radicular pain. The claimant has undergone multiple conservative treatment modalities and continues with low back pain with associated radiculopathy. The Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months. There is no documentation of this response to previous epidural steroid injection therapy. Medical necessity for the requested lumbar steroid injection has not been established. The requested treatment is not medically necessary.