

Case Number:	CM13-0047795		
Date Assigned:	12/27/2013	Date of Injury:	05/18/2010
Decision Date:	05/22/2014	UR Denial Date:	10/21/2013
Priority:	Standard	Application Received:	11/04/2013

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, and is licensed to practice in Texas. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 33-year-old male who reported an injury on May 18, 2010. The injury reportedly occurred when he was pulling poles out of the ground and carrying them to the truck, he started to experience pain to the lower back. His symptoms included a pain level of 8/10. Physical examination revealed a decrease in range of motion of the lumbar spine and a positive straight leg raise. The injured worker was diagnosed with displacement of lumbar intervertebral disc without myelopathy. Past medical treatment included physical therapy, laminotomy and discectomy at L5-S1 on January 25, 2011, and oral medications. Diagnostic studies were not included in the medical records. The request for authorization was not provided in the medical records. Therefore, the clinical note from the date the treatment was requested is unclear.

IMR ISSUES, DECISIONS AND RATIONALES

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

NEUROLYSIS OF LEFT S1 NERVE ROOT WITH WYDASE: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation non-mtus.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES (ODG) LOW BACK, ADHESIOLYSIS, PERCUTANEOUS.

Decision rationale: The California MTUS/ACOEM Guidelines do not address. According to the Official Disability Guidelines, percutaneous adhesiolysis is not recommended due to the lack of sufficient literature evidence. It is a treatment for chronic back pain that involves disruption, reduction, and/or elimination of fibrous tissue from the epidural space. Lysis of adhesions is carried out by catheter manipulation and/or injection of saline. Epidural injection of local anesthetic and steroid is also performed. It has been suggested that the purpose of the intervention is to eliminate the effect of scar formation, allowing for a direct application of drugs to the involved nerves and tissue, but the exact mechanism of success has not been determined. There is large amount of variability in the technique used, and the technical ability of the physician appears to play a large role in the success of the procedure. In addition, research into the identification of the patient who is best served by this intervention remains largely uninvestigated. Given the limited evidence available for percutaneous epidural adhesiolysis, it is recommended that this procedure be regarded as investigational at this time. The documentation submitted for review failed to provide a rationale for the requested treatment. There was no documentation of failed conservative treatment including epidural steroid injections or any indication the physician had suspicion of adhesions blocking access to the nerve. Due to the limited evidence available for percutaneous epidural adhesiolysis, the request is not supported. The request for neurolysis of the left S1 nerve root with wydase is not medically necessary or appropriate.

LEFT S1 TRANSFORAMINAL EPIDURAL STEROID INJECTION UNDER FLUOROSCOPY: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs) Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines EPIDURAL STEROID INJECTIONS (ESIs) Page(s): 46.

Decision rationale: According to the Chronic Pain Medical Treatment Guidelines, epidural steroid injections are recommended as an option for treatment of radicular pain for patients who are initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs [non-steroidal anti-inflammatory drugs], and muscle relaxants). Final Determination Letter for IMR Case Number CM13-0047795 4 The Guidelines also state radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. The documentation submitted for review indicated the injured worker had a decrease in range of motion to the lumbar spine and a positive straight leg raise. However, in the absence of documented objective findings of radiculopathy upon examination corroborated by positive nerve impingement upon official MRI, the request is not supported. The request for left S1 transforaminal epidural steroid injection under fluoroscopy is not medically necessary or appropriate.