MAXIMUS Federal Services

Case Number:	CM13-0061774		
Date Assigned:	12/30/2013	Date of Injury:	06/09/2007
Decision Date:	05/21/2014	UR Denial Date:	11/18/2013
Priority:	Standard	Application Received:	12/05/2013

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 Anesthesiology, has a subspecialty in Acupuncture and Pain Medicine and is licensed to practice in California. 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:

This case involves a 52-year-old female injured worker, with date of injury of 6/9/07, with related low back pain with radicular symptoms radiating down into bilateral legs. She also complains of pain in the cervical spine. In 12/2013 she was seen in the Emergency Room (ER), due to increased pain and was given prednisone, Flexeril and injection. Per the 12/10/13 note, an examination of the lumbar spine revealed pain on extension, with positive straight leg raise. There was discomfort to palpation along the distal lumbar segments. Hypoesthesia over anterolateral aspect of foot and ankle was noted. An MRI of the cervical spine dated 05/10/10, revealed at C4-C5 mild disc protrusion that abuts the thecal sac. At C5-C6, there is mild to moderate disc protrusion that abuts the spinal cord producing mild spinal canal narrowing. There is moderate neuroforaminal narrowing. There is bilateral facet and uncinate arthropathy noted. An MRI of the lumbar spine dated 05/10/10, revealed at L3-L4, mild disc protrusion that abuts the thecal sac. At L4-L5, there is facet and ligamentum flavum hypertrophy that produces mild spinal canal narrowing. At L5-S1, there is mild to moderate disc protrusion that abuts the thecal sac. There is mild spinal canal narrowing and moderate neuroforaminal narrowing. Straightening of lumbar lordosis, mild levoscoliosis is noted. The injured worker was refractory to physical therapy, chiropractic care, and medication management. The date of utilization review (UR) decision was 11/18/13.

IMR ISSUES, DECISIONS AND RATIONALES

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

LUMBAR EPIDURAL STEROID INJECTIONS AT L2-L3, L3-L4, L4-L5, AND L5-S1, WITH EPIDUROGRAM, ONCE A WEEK FOR TWO (2) WEEKS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation EUR SPINE J. 2010 SEP; 19(9): 1479-83. DOI: 10.1007/S00586-010-1469-8. EPUB 2010 MAY 29.

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

Decision rationale: The Chronic Pain Guidelines indicate that epidural steroid injections are used to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs and avoiding surgery, but this treatment alone offers no significant long-term benefit. "The criteria for the use of epidural steroid injections are as follows: 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). 3) Injections should be performed using fluoroscopy (live x-ray) for guidance. 4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections. 5) No more than two nerve root levels should be injected using transforaminal blocks. 6) No more than one interlaminar level should be injected at one session. 7) 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 (6-8) weeks, with a general recommendation of no more than four (4) blocks per region per year. 8) Current research does not support a "series-of-three" injection in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections." According to the guidelines, no more than one (1) interlaminar level should be injected at one (1) session. Since the request represents injections at L2-L3, L3-L4, L4-L5, and L5-S1, the request is not medically necessary.

PHYSICAL THERAPY FOR THE LUMBAR SPINE, TWO (2) TIMES A WEEK FOR SIX (6) WEEKS: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES, ODG-TWC NECK & UPPER BACK PROCEDURE SUMMARY (LAST UPDATED 05/14/2013) AND THE LOW BACK PROCEDURE SUMMARY (LAST UPDATED 10/09/2013).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines PHYSICAL MEDICINE Page(s): 98-99.

Decision rationale: The Chronic Pain Guidelines allow for fading of treatment frequency (from up to 3 visits per week to 1 or less), plus active self-directed home Physical Medicine. It is recommended that for myalgia and myositis: nine to ten (9-10) visits over eight (8) weeks; and

for Neuralgia, neuritis, and radiculitis: eight to ten (8-10) visits over four (4) weeks. The records submitted for review state that the injured worker has failed conservative therapy with physical therapy and chiropractic care. It is not indicated in the documentation how many sessions of physical therapy the injured worker had previously completed. This request represents twelve (12) sessions of physical therapy directed at the lumbar spine, which exceeds the guideline recommendation of ten (10) visits. The request is not medically necessary.

PRE-OPERATIVE LABS: COMPLETE BLOOD COUNT (CBC): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES, ODG-TWC (LAST UPDATED 05/10/2013).

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, PREOPERATIVE LAB TESTING

Decision rationale: The Official Disability Guidelines indicate, "preoperative lab testing should be guided by the patient's clinical history, comorbidities, and physical examination findings. Preoperative routine tests are appropriate if patients with abnormal tests will have a preoperative modified approach (i.e., new tests ordered, referral to a specialist or surgery postponement). Testing should generally be done to confirm a clinical impression, and tests should affect the course of treatment." The criteria for preoperative lab testing include: - Preoperative urinalysis is recommended for patients undergoing invasive urologic procedures and those undergoing implantation of foreign material. - Electrolyte and creatinine testing should be performed in patients with underlying chronic disease and those taking medications that predispose them to electrolyte abnormalities or renal failure. - Random glucose testing should be performed in patients at high risk of undiagnosed diabetes mellitus. - In patients with diagnosed diabetes, A1C testing is recommended only if the result would change perioperative management. - A complete blood count is indicated for patients with diseases that increase the risk of anemia or patients in whom significant perioperative blood loss is anticipated. - Coagulation studies are reserved for patients with a history of bleeding or medical conditions that predispose them to bleeding, and for those taking anticoagulants. The documentation provided for review does not indicate that the injured worker has any co-morbidity that necessitates preoperative labs. Furthermore, the requested epidural steroid injection was not medically necessary. This request is not medically necessary.

PRE-OPERATIVE LABS: SMA 7: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES, ODG-TWC (LAST UPDATED 05/10/2013).

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, PREOPERATIVE LAB TESTING.

Decision rationale: The Official Disability Guidelines indicate, "preoperative lab testing should be guided by the patient's clinical history, comorbidities, and physical examination findings. Preoperative routine tests are appropriate if patients with abnormal tests will have a preoperative modified approach (i.e., new tests ordered, referral to a specialist or surgery postponement). Testing should generally be done to confirm a clinical impression, and tests should affect the course of treatment." The criteria for preoperative lab testing include: - Preoperative urinalysis is recommended for patients undergoing invasive urologic procedures and those undergoing implantation of foreign material. - Electrolyte and creatinine testing should be performed in patients with underlying chronic disease and those taking medications that predispose them to electrolyte abnormalities or renal failure. - Random glucose testing should be performed in patients at high risk of undiagnosed diabetes mellitus. - In patients with diagnosed diabetes, A1C testing is recommended only if the result would change perioperative management. - A complete blood count is indicated for patients with diseases that increase the risk of anemia or patients in whom significant perioperative blood loss is anticipated. - Coagulation studies are reserved for patients with a history of bleeding or medical conditions that predispose them to bleeding, and for those taking anticoagulants. The documentation provided for review does not indicate that the injured worker has any co-morbidity that necessitates preoperative labs. Furthermore, the requested epidural steroid injection was not medically necessary. This request is not medically necessary.

PRE-OPERATIVE LABS: PTT, PT & INR: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES, ODG-TWC (LAST UPDATED 05/10/2013).

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, PREOPERATIVE LAB TESTING.

Decision rationale: The Official Disability Guidelines indicate, "preoperative lab testing should be guided by the patient's clinical history, comorbidities, and physical examination findings. Preoperative routine tests are appropriate if patients with abnormal tests will have a preoperative modified approach (i.e., new tests ordered, referral to a specialist or surgery postponement). Testing should generally be done to confirm a clinical impression, and tests should affect the course of treatment." The criteria for preoperative lab testing include: - Preoperative urinalysis is recommended for patients undergoing invasive urologic procedures and those undergoing implantation of foreign material. - Electrolyte and creatinine testing should be performed in patients with underlying chronic disease and those taking medications that predispose them to electrolyte abnormalities or renal failure. - Random glucose testing should be performed in patients at high risk of undiagnosed diabetes mellitus. - In patients with diagnosed diabetes, A1C testing is recommended only if the result would change perioperative management. - A complete blood count is indicated for patients with diseases that increase the risk of anemia or patients in whom significant perioperative blood loss is anticipated. - Coagulation studies are reserved for patients with a history of bleeding or medical conditions that predispose them to bleeding, and

for those taking anticoagulants. The documentation provided for review does not indicate that the injured worker has any co-morbidity that necessitates preoperative labs. Furthermore, the requested epidural steroid injection was not medically necessary. This request is not medically necessary.