

Case Number:	CM14-0100679		
Date Assigned:	07/30/2014	Date of Injury:	08/30/2011
Decision Date:	09/09/2014	UR Denial Date:	06/20/2014
Priority:	Standard	Application Received:	06/30/2014

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 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:

The patient is a 43 year old male who sustained an industrial injury on 06/30/2011. He is status post lumbar fusion with instrumentation. A prior Utilization Review peer review determination on 6/20/2014 not medically necessary the requested Transforaminal Injection to right L4-5, L5-S1, and Trial of spinal cord stimulator. The patient had a Lumbar ESI on 10/20/11 and received 15% improvement. Although the patient has persistent pain complaints, there is no clear evidence that he has had psychological evaluation and clearance that would justify pain is not primarily psychological in origin. An EMG/NCV of the lower extremities was performed on 5/6/2014 which provided the impression: 1. Normal EMG of bilateral lower extremities without electrodiagnostic evidence of acute or chronic right or left lumbar or S1 nerve root involvement. 2. Electrodiagnostic findings of distal right peroneal neuropathy across the right ankle, however, without electrodiagnostic evidence of peroneal nerve involvement across the right knee or fibular head. 3. No electrodiagnostic evidence of peripheral neuropathy. The patient had a follow up with PTP/Orthopedic Surgeon on 6/13/2014. According to the PR-2, he complains of not doing well, having worse back, and leg pain. Since his last visit, he underwent lumbar MRI and an EMG. He is depressed, has difficulty sleeping, stiffness of the back, neck pain intractable and right lower extremity symptoms. Physical examination reveals lumbar spine is very stiff, spasm and tenderness, ROM 45 degrees flexion, and 5 degrees extension. Review of lumbar MRI shows 3 mm disc protrusion at L4-5 with stenosis. Diagnoses are 1. Status post back surgery including fusion times two; 2. Failed back; 3. Right leg radiculopathy; 4. Depression and anxiety; and 5. Difficulty sleeping. Treatment plan includes recommendation for one more epidural injection, continue pain management, TTD status, spinal cord stimulator trial, and request to review EMG/NCV study report. The patient had a pain management re-evaluation on 6/19/2014, with complaint of still experiencing pain on the lower back shooting down the right

leg radiating to the foot. Pain medication helps a little. He finds relief with reclining on a recliner chair. He feels sensation of numbness and tingling in the right leg as well. He has trouble sleeping due to pain, and is taking Ambien to help sleep. Pain is rated 8/10 on VAS. Physical examination reveals moderate tenderness in the upper trapezius, normal sensation in the left and right extremities, moderate tenderness in the bilateral SI joint and iliolumbar, as well as right gluteus, hip, thigh, knee, leg and ankle. Reduced lumbar ROM with pain. He has normal muscle tone bilaterally. Sensory examination is normal on the left and decreased on the right. Reflexes are 1+ right patellar, and 2+ left patellar and bilateral Achilles. Sitting and supine SLR and sciatic tension signs are positive on the right. Diagnoses are lumbar disc displacement/herniation; spondylosis with myelopathy, lumbar region; neuralgia, neuritis, and radiculitis; degeneration of lumbar or lumbosacral IVD; nerve root compression, lumbar; spinal stenosis of lumbar region; lumbago; and facet joint syndrome. Treatment plan includes follow-up with surgeon, review MRI with patient; discontinue diluadid, prescribe Percocet #120, Valium 330, Gabapentin #90; trial SCS and recommend TLESI at right L4-5, L5-S1; and follow-up in one month. Requests authorization for transforaminal nerve injection right L4-5, L5-S1, and trial spinal cord stimulator.

IMR ISSUES, DECISIONS AND RATIONALES

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

Transforaminal Injection to Right L4-5, L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections.

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

Decision rationale: As per CA MTUS guidelines, Epidural Steroid Injections (ESIs) are recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). Epidural Steroid Injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. There is little information on improved function. In this case, there is insufficient documentation to support the necessity of the requested procedure. There is no imaging or Electrodiagnostic evidence of nerve root compression. There is no clear evidence of radiculopathy (radiating pain in a dermatomal distribution in the lower extremities) at the levels being requested for TF-ESI. There is no evidence of prior trial and failure of conservative management. Therefore, the request is considered not medically necessary according to guidelines and based on the available clinical information.

Trail of Spinal Cord Stimulator: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Spinal Cord Stimulators.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Spinal cord stimulators (SCS) Page(s): 105-106.

Decision rationale: According to the CA MTUS guidelines, Spinal Cord Stimulators (SCS) is recommended only for selected patients in cases when less invasive procedures have failed or are contraindicated, for specific conditions (i.e. CRPS and failed back surgery syndrome) following a successful temporary trial. The medical records do not document trial and failure of all conservative treatments including physical therapy. There is no clear evidence of psychological evaluation prior to implantation per guidelines. Therefore, the request is considered not medically necessary according to the guidelines.