

Case Number:	CM14-0023499		
Date Assigned:	05/14/2014	Date of Injury:	08/22/2012
Decision Date:	07/24/2014	UR Denial Date:	02/13/2014
Priority:	Standard	Application Received:	02/24/2014

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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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:

Patient is a 52-year-old male who has submitted a claim for herniated lumbar disc and lumbar radiculitis associated with an industrial injury date of August 22, 2012. Patient complained of low back pain, graded 6 to 7/10 in severity, radiating into the right lower extremity. Patient denied weakness of lower extremities. Aggravating factors included prolonged standing, lifting, bending, and coughing. Pain was relieved by intake of medications, rest, and massage. Physical examination revealed facet tenderness at left L4 to S1 levels bilaterally. Range of motion of the lumbar spine towards flexion, right lateral flexion, and right rotation were restricted. Straight leg raise test was positive bilaterally. Reflexes were normal. Magnetic Resonance Imaging (MRI) of the lumbar spine, dated May 21, 2013, showed multi-level facet disease, left paracentral disc protrusion at L3 to L4, moderate canal stenosis at L4 to L5 due to broad-based disc bulging and hypertrophic changes, and stenoses at L5 to S1 with foraminal narrowing at L4 to L5 and L5 to S1 levels. Electrodiagnostic study, dated June 12, 2013, showed bilateral chronic active L5-S1 radiculopathy, right side greater than left. Treatment to date has included physical therapy, chiropractic care, acupuncture, medications, and therapeutic epidural administration of Kenalog and Marcaine for analgesia; therapeutic percutaneous epidural decompression neuroplasty of the lumbosacral nerve roots for analgesia of left L4 and L5 levels; epidurogram-myelogram without dural puncture; multiplanar fluoroscopy - c arm for needle placement, and lumbosacral AP and Lat on 12/6/2013. Utilization review from February 13, 2014 denied the requests for injection diagnosis lumbar/sacral, lumbosacral AP & Lat, myelogram lumbosacral, therapeutic percutaneous epidural decompression neuroplasty left L4 for analgesia, and therapeutic percutaneous epidural decompression neuroplasty left L5 for analgesia because of no evidence of failure in conservative care.

IMR ISSUES, DECISIONS AND RATIONALES

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

INJECTION DIAGNOSIS LUMBAR/SACRAL QUANTITY 1.00: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20-9792.26, EPIDURAL STEROID INJECTION Page(s): 46.

Decision rationale: As stated on page 46 of California Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines, epidural steroid injection (ESI) is indicated among patients with radicular pain that has been unresponsive to initial conservative treatment. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 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. In this case, patient had persistent low back pain radiating to the right lower extremity. Diagnostic epidural injection was performed on 12/06/2013 due to failure of conservative management. However, medical records submitted and reviewed failed to document the number of sessions completed in physical therapy, chiropractic care, and acupuncture. Failure of conservative care cannot be established due to insufficient information. The medical necessity was not established. Therefore, the request for injection diagnosis lumbar/sacral is not medically necessary.

LUMBROSACRAL AP & LAT QUANTITY 1.00: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: The related requests for diagnostic injection and therapeutic percutaneous epidural decompression neuroplasty have been deemed not medically necessary; therefore, all the associated services, such as this request for lumbosacral AP and Lat is likewise not medically necessary.

MYELOGRAM LUMBROSACRAL QUANTITY 1.00: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: The related requests for diagnostic injection and therapeutic percutaneous epidural decompression neuroplasty have been deemed not medically necessary; therefore, all

the associated services, such as this request for myelogram lumbosacral is likewise not medically necessary.

THERAPEUTIC PERCUTANEOUS EPIDURAL DECOMPRESSION NEUROPLASTY LEFT L4 FOR ANALGESIA QUANTITY 1.00: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20-9792.26, EPIDURAL STEROID INJECTION Page(s): 46.

Decision rationale: As stated on page 46 of California Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines, epidural steroid injection (ESI) is indicated among patients with radicular pain that has been unresponsive to initial conservative treatment. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. If used for diagnostic purposes, a maximum of two injections should be performed. In this case, patient had persistent low back pain radiating to the right lower extremity. Epidural decompression neuroplasty was performed on 12/06/2013 due to failure of conservative management. However, medical records submitted and reviewed failed to document the number of sessions completed in physical therapy, chiropractic care, and acupuncture. Failure of conservative care cannot be established due to insufficient information. The medical necessity was not established. Therefore, the request for Therapeutic percutaneous epidural decompression neuroplasty left l4 for analgesia is not medically necessary.

THERAPEUTIC PERCUTANEOUS EPIDURAL DECOMPRESSION NEUROPLASTY LEFT L5 FOR ANALGESIA QUANTITY 1.00: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20-9792.26, EPIDURAL STEROID INJECTION Page(s): 46.

Decision rationale: As stated on page 46 of California Medical Treatment Utilization Schedule (MTUS) Chronic Pain Medical Treatment Guidelines, epidural steroid injection (ESI) is indicated among patients with radicular pain that has been unresponsive to initial conservative treatment. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. If used for diagnostic purposes, a maximum of two injections should be performed. In this case, patient had persistent low back pain radiating to the right lower extremity. Epidural decompression neuroplasty was performed on 12/06/2013 due to failure of conservative management. However, medical records submitted and reviewed failed to document the number of sessions completed in physical therapy, chiropractic care, and acupuncture. Failure of conservative care cannot be established due to insufficient information. The medical necessity was not established. Therefore, the request for Therapeutic percutaneous epidural decompression neuroplasty left l5 for analgesia is not medically necessary.

