MAXIMUS Federal Services

Case Number:	CM14-0023523		
Date Assigned:	05/12/2014	Date of Injury:	08/22/2012
Decision Date:	07/21/2014	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 Occupational 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:

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. 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. Previous utilization review was not made available.

IMR ISSUES, DECISIONS AND RATIONALES

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

RETROSPECTIVE MYELOGRAPHY, LUMBOSACRAL, RADIOLOGICAL SUPERVISION QTY: 2 DOS: 11/22/13 & 12/6/13: 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 based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Section, Myelography.

Decision rationale: The Official Disability Guideline states that invasive evaluation by means of myelography may be supplemental when visualization of neural structures is required for specific problem solving. As stated on page 46 of Chronic Pain Medical Treatment Guidelines, epidural steroid injection (ESI) is indicated among patients with radicular pain that has been unresponsive to initial conservative treatment. In this case, patient had persistent low back pain radiating to the right lower extremity. Both diagnostic and therapeutic epidural injection were 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 retrospective Myelography, Lumbosacral, Radiological supervision qty: 2 dos: 11/22/13 & 12/6/13 is not medically necessary.

RETROSPECTIVE RADIOLOGIC EXAMINATION, SPINE, LUMBOSACRAL; 2 OR 3 VIEWS DOS: 11/22/13 & 12/6/13: 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 Chronic Pain Medical Treatment Guidelines, epidural steroid injection (ESI) should be performed using live x-ray for guidance. It is indicated among patients with radicular pain that has been unresponsive to initial conservative treatment. In this case, patient had persistent low back pain radiating to the right lower extremity. Both diagnostic and therapeutic epidural injection were 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 retrospective Radiologic examination, Spine, Lumbosacral; 2 or 3 views dos: 11/22/13 & 12/6/13 is not medically necessary.

RETROSPECTIVE FLUOROSCOPY (SEPARATE PROCEDURE), UP TO 1 HOUR PHYSICIAN TIME DOS: 11/22/13 & 12/6/13: 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 Chronic Pain Medical Treatment Guidelines, epidural steroid injection (ESI) should be performed using fluoroscopy (live x-ray) for guidance. It is indicated among patients with radicular pain that has been unresponsive to initial conservative treatment. In this case, patient had persistent low back pain radiating to the right lower extremity. Both diagnostic and therapeutic epidural injection were 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 retrospective Fluoroscopy (separate procedure), up to 1 hour physician time dos: 11/22/13 & 12/6/13 is not medically necessary.