MAXIMUS Federal Services

Case Number:	CM14-0040337		
Date Assigned:	06/27/2014	Date of Injury:	01/31/2012
Decision Date:	07/29/2014	UR Denial Date:	03/17/2014
Priority:	Standard	Application Received:	04/07/2014

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 & Rehabilitation has a subspecialty in 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:

The patient is a 47-year-old female with an industrial injury date of 1/31/2012, from unknown cause. She was diagnosed with L4-L5 spondylolisthesis with neuroforaminal stenosis, right lower extremity claudication. She underwent L4-5 laminectomy and fusion on 3/7/2013. She also has prior history of cervical complaints. A CT scan of the lumbar spine on 6/12/2014 provided the conclusion: 1. Moderate bilateral foraminal narrowing and central canal narrowing at L3-L4 suggested, above the level of fusion. 2. Posterior instrumented lateral mass and decompression at the L4-L5 level hardware intact and patent appearing central canal. Patient underwent a Qualified medical evaluation on 4/7/2014. Physical examination findings included diminished sensation of the left and right S1 distribution, 5/5 motor strength, trace right and left patellar reflex, 0, right and Tracy left ankle reflex, and SLR and Lasegue's at positive 90. Future medical care recommendations included physician visits, medications for any flares, appropriate diagnostic studies including CT of the lumbar spine to evaluate the fusion, physical therapy and consultations with TOS expert, with dental, panel psychiatrist and panel urologist. The patient had a follow-up with her primary treating physician on 5/27/2014. She complains of continued pain in the back and bilateral upper extremities. She states the neuropathy radiates into the arms down to the fingers as well as down to both legs. She reports increased stress due to personal relationship issues. She is going to counseling on a regular basis.Pain is rated 5/10. Her current medications include Tizanidine, Norco, gabapentin, Cymbalta, volume, Lidoderm 5% patch, and Zoloft. She smoked pack of cigarettes a day. Physical examination reveals the patient to be well-nourished, or no acute distress, speech is fluid, cognition is intact, and cranial nerves are normal. A lumbar examination was not performed. Medications were renewed and a urine toxicology screen was ordered.

IMR ISSUES, DECISIONS AND RATIONALES

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

Caudal epidural with RACZ catheter under fluoroscopic guidance with anesthesia: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for use of Epidural steroid injections.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Pain, Epidural Steroid Injections.

Decision rationale: According to the guidelines, ESI is recommended as an option to treat radicular pain. The guidelines outline that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. In this case, the patient's recent CT scan showed no evidence of a neurocompressive lesion present. The central canal is patent. The diminished sensory and reflexes are consistent with the preoperative diagnosis. There is no indication of any significant change in her clinical presentation. In addition, injections should be performed using fluoroscopy, however, anesthesia is not required. Furthermore, RACZ catheter procedure is not recommended according to the guidelines. According to the ODG, percutaneous adhesiolysis, (also referred to as epidural neurolysis, epidural neuroplasty, or lysis of epidural adhesions) is not recommended due to the lack of sufficient literature evidence (risk vs. benefit, conflicting literature). Therefore the request for caudal epidural with RACZ catheter under fluoroscopic guidance with anesthesia is not medically necessary.