MAXIMUS Federal Services

Case Number:	CM14-0188977		
Date Assigned:	11/19/2014	Date of Injury:	06/28/2013
Decision Date:	02/11/2015	UR Denial Date:	10/29/2014
Priority:	Standard	Application Received:	11/12/2014

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 Rehab, has a subspecialty in Neuromuscular Medicine and is licensed to practice in Maryland. 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 45 year old male with a date of work injury 6/28/13. The diagnoses include lumbar disc disease, lumbar radiculopathy, incapacitating back pain with left lower extremity and paresthesias and lumbar stenosis at L3 to S1; left ankle sprain,strain, and osteochondral posteromedial talar dome lesion. Per documentation a progress note dated 10/21/2014, stated that this patient recent underwent a midline lumbar epidural steroid injection which was much more effective. The benefits lasted up to 10 days before fading away. The provider stated that the patient has erectile dysfunction for the last six months and continues to have ongoing left ankle pain. He is not walking well enough to care for his children. The physical examination, the provider states, is unchanged. The treatment requested is authorization for repeat midline lumbar epidural steroid injection, evaluation/treatment foot-ankle orthopedic specialist, evaluation by a urologist and request for a motorized wheelchair. Magnetic Resonance Imaging (MRI) of the lumbar spine dated 10/23/2013 documented central canal stenosis and tapering from L3 down to SI from epidural lipomatosis. There is no disc herniation or bulge and no foraminal narrowing. An 11/11/13 electrodiagostic study revealed that there is electrodiagnostic evidence of a possible mild left L4 or L4 lumbar radiculopathy with minimal evidence of ongoing denervation. Per documentation a 06/03/2014 progress note stated that that the patient continued to be in pain. The patient was very tired of being in chronic pain. The patient complained of low backpain and left ankle and foot junction like pain and stated that the foot was feeling like it was burning in acid. On physical examination, the patient grimaced and was walking with a limp, requiring a cane. Motor strength of the upper extremities is 5/5 and equal. Motor strength of the lower extremities is 5/5 and equal Sensation is intact to light touch in all major dermatom.al groups. His deep tendon reflexes are 2+ throughout. The patient had an epidural steroid injection (ESI) at L3-L4 and L4-L5 levels on06/24/2014. The patient was using a cane and was taking

Norco, Gabapentin and Etodolac. Per 11/18/14 document on ankle MRI there is no evidence of any soft tissue injury to the ankle whatsoever. All of the tendons and ligaments are intact without any edematous changes, and this does not seem to be a soft tissue injury of the ankle consistent with a sprain or strain. Rather, it seems the patient has developed an osteochondral lesion of the talus secondary to trauma, and he should undergo specialized surgical consultation in regard to this. A 12/1/14 document states that think it is unlikely that he will have significant improvement in his lumbar spine-related pain complaints until he receives adequate treatment for his left ankle.

IMR ISSUES, DECISIONS AND RATIONALES

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

Motorized wheelchair: 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)

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Power mobility devices (PMDs) Page(s): 98-99.

Decision rationale: A motorized wheelchair is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines state that a power mobility device is not recommended if the functional mobility deficit can be sufficiently resolved by the prescription of a cane or walker, or the patient has sufficient upper extremity function to propel a manual wheelchair, or there is a caregiver who is available, willing, and able to provide assistance with a manual wheelchair. The documentation indicates that the patient ambulates with a cane. There is no indication that he would not be able to propel a manual wheelchair. The request for a motorized wheelchair is not medically necessary.

Three Midline Transforaminal Epidural Steroid Injections at L3-4: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections Page(s): 46.

Decision rationale: Three Midline Transforaminal Epidural Steroid Injections at L3-4 are not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines state that 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 weeks, with a general recommendation of no more than 4 blocks per region per year. The current research does not support a "series-of-three" injections in either the diagnostic or therapeutic phase. The MTUS recommends no more than 2 injections. The guidelines do not recommend more than 2 injections. The MTUS states that 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 weeks, with a general recommendation of no more than 4 blocks .per region per year. The documentation indicates that the patient had a failed transforaminal injection at L3-4 on 6/24/14 and the provider would like to perform a midline injections. The documentation indicates that the patient did not have evidence of significant benefit from prior L3-4 injection. Additionally, the guidelines do not recommend more than one injection at a time without continued evidence of efficacy, functional improvement, and medication reduction. The request for three midline transforaminal epidural steroid injections at L3-4 is not medically necessary.

Referral to ankle foot specialist: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management, Chapter 14 Ankle and Foot Complaints Page(s): 92,Chronic Pain Treatment Guidelines Functional Restoration Approach to Chronic Pain Management Page(s): 7. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Office Visits

Decision rationale: Referral to ankle foot specialist is medically necessary per the MTUS Chronic Pain and Official Disability Guidelines. The MTUS states that for patients with more complex or refractory problems, a comprehensive multidisciplinary approach to pain management that is individualized, functionally oriented (not pain oriented), and goal-specific has been found to be the most effective treatment approach. The MTUS ACOEM states that referral may be appropriate if the practitioner is uncomfortable with the line of inquiry, with treating a particular cause of delayed recovery or has difficulty obtaining information or agreement to a treatment plan. The Official Disability Guidelines states that evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. The documentation indicates that the patient has chronic ankle pain and the patient feels that he has not had appropriate care for this from a specialist. His treating physician feels that the he will not have appropriate relief from his low back complaints unless his ankle issue is addressed. A referral to an ankle specialist is appropriate and medically necessary.

Referral to Urologist for erectile dysfunction: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 127. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 92,Chronic Pain Treatment Guidelines Functional Restoration Approach to Chronic Pain Management Page(s): 7. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain, Office Visits

Decision rationale: Referral to Urologist for erectile dysfunction is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The MTUS states that for patients with more complex or refractory problems, a comprehensive multidisciplinary approach to pain management that is individualized, functionally oriented (not pain oriented), and goal-specific has been found to be the most effective treatment approach. The MTUS ACOEM states that referral may be appropriate if the practitioner is uncomfortable with the line of inquiry outlined above, with treating a particular cause of delayed recovery (such as substance abuse), or has difficulty obtaining information or agreement to a treatment plan. The Official Disability Guidelines states that evaluation and management (E&M) outpatient visits to the offices of medical doctor(s) play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for a clinical office visit with a health care provider is individualized based upon a review of the patient concerns, signs and symptoms, clinical stability, and reasonable physician judgment. A 12/29/14 document states that the patient was given Viagra for erectile dysfunction. Furthermore, the documentation does not indicate that the provider has reviewed possible causes of erectile dysfunction prior to referral. The documentation does not indicate yet if the patient continues to have erectile dysfunction after a Viagra trial. Without this additional information, a referral to urologist is not medically necessary.