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| Case Number: | CM15-0106224 | | |
| Date Assigned: | 06/10/2015 | Date of Injury: | 05/19/2014 |
| Decision Date: | 08/25/2015 | UR Denial Date: | 05/20/2015 |
| Priority: | Standard | Application Received: | 06/02/2015 |

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 injured worker is a 48-year-old male, with a reported date of injury of 05/19/2014. The diagnoses include lumbar spine musculoligamentous sprain/strain with left lower extremity radiculitis, lumbar disc disease, lumbar radiculopathy, lumbar facet syndrome, and left sacroiliac joint sprain/strain. Treatments to date have included an MRI of the lumbar spine on 11/20/2014 which showed broad 4mm midline disc protrusion with a mild degree of central canal narrowing; oral medication; physical therapy, chiropractic treatment, and home exercise program. The comprehensive pain management consultation report dated 04/14/2015 indicates that the injured worker complained of pain in the low back which was rated 7 out of 10. The physical examination showed an antalgic gait to the left, heel-toe walk exacerbated the antalgic gait to the left, tenderness over the lumbar spine paraspinal muscles, facet tenderness over L4-S1, positive left sacroiliac tenderness, positive left straight leg raise test, decreased lumbar spine range of motion, and decreased sensation in the left L5 and S1 dermatomes. The treating physician requested left L5-S1 and bilateral S1 epidural steroid injection in the lumbar spine; pre-operative medical clearance evaluation consultation; initial post-operative physical therapy for the lumbar spine; and a cold therapy unit for the lumbar spine. It was noted that the injured worker had radicular symptoms on physical examination and neuroforaminal stenosis, nerve root compression, and posterior annular tear on MRI. He had failed conservative treatments more than six weeks over the past twelve months.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left L5-S1 and Bilateral S1 ESI Lumbar Spine: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ESI Page(s): 46.

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

Decision rationale: Based on the 05/04/15 progress report provided by treating physician, the patient presents with low back pain radiating to the bilateral lower extremities. The patient is status post left ankle ORIF surgery 05/19/14, and hardware removal 04/30/15. The request is for associated surgical service: left L5-S1 and bilateral S1 ESI lumbar spine. Patient's diagnosis per Request for Authorization form dated 04/14/15 includes lumbar disc disease, lumbar radiculopathy, lumbar facet syndrome, and left sacroiliac joint sprain/strain. Diagnosis per RFA dated 05/04/15 included "lumbar spine musculoligamentous sprain/strain with left lower extremity radiculitis, facet arthropathy and spondylosis, per x-ray, with L5-S1 four-millimeter midline disc protrusion with posterior annular tear abutting the descending bilateral S1 nerve roots with mild central canal narrowing and mild degenerative endplate changes and L3-L4 and L4-L5 one millimeter disc bulge with mild facet arthropathy without stenosis." The patient ambulates with a slow gait. Treatment to date has included imaging studies, physical therapy, chiropractic, home exercise program, and medications. The patient is temporarily totally disabled, per 04/15/15 report. MTUS Chronic Pain Treatment Guidelines, section on Epidural steroid injections (ESIs) page 46 states these are recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). The MTUS Criteria for the use of Epidural steroid injections states: Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 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. Physical examination to the lumbar spine on 05/04/15 revealed tenderness over the lumbar spine paraspinal muscles. Range of motion was decreased, especially on extension 10 degrees. Positive straight leg raise test bilaterally, and decreased sensation in the L4 through S1 dermatomes. MRI of the lumbar spine dated 11/20/14 states "At L5-S1, there is a broad 4-mm midline disc protrusion resulting in abutment of the descending S1 nerve roots bilaterally with a mild degree of canal narrowing." Per 04/14/15 report, treater states "The patient has radicular symptoms on physical examination and neuroforaminal stenosis, nerve root compression and a posterior annular tear on MRI. He has failed conservative treatment including physical therapy, chiropractic treatment, medications, rest and home exercise program more than six weeks over the past 12 months." In this case, treater has documented patient's radicular symptoms, supported by physical examination and corroborated with MRI, as required by MTUS. Given patient's continued symptoms, diagnosis and documentation, lumbar ESI would appear to be indicated. However, UR letter dated 05/20/15 states "This patient had previously been certified for one epidural block on 5/1/15." Progress report dated 05/04/15 states "Pending response for left L5-S1 and bilateral S1 epidural injections with [REDACTED]." Based on medical records, this appears to be a request for

repeat ESI. In this case, repeat injections would not be supported by MTUS, without documentation of significant improvement lasting at least 6-8 weeks. This request is not in accordance with guideline indications. Therefore, the request is not medically necessary.

Pre-Op Medical Clearance Evaluation Consultation: 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Initial Post-Op PT 2x4 Lumbar Spine: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Lumbar & Thoracic (Acute & Chronic) Chapter under Physical therapy (PT).

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Associated Surgical Service: Cold Therapy Unit Lumbar Spine: 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: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.