MAXIMUS Federal Services

Case Number:	CM15-0191369		
Date Assigned:	10/05/2015	Date of Injury:	08/20/2013
Decision Date:	11/18/2015	UR Denial Date:	09/11/2015
Priority:	Standard	Application Received:	09/29/2015

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: Massachusetts
Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 62 year old male, who sustained an industrial injury on 8-20-2013. The injured worker is being treated for grade I spondylolisthesis L4 on L5, marked facet arthrosis and lumbar spondylosis, concomitant severe spinal canal stenosis L4-5 and left leg lumbar spondylitic radiculitis. Treatment to date has included diagnostics, physical therapy, chiropractic care and medications. He underwent a lumbar epidural steroid injection (ESI) on 7-10-2015. Per the Primary Treating Physician's Progress Report dated 8-28-2015, the injured worker reported minimal lower lumbar back pain but severe radicular complaints of leg pain, numbness and tingling. He initially reported marked improvement in his condition of approximately 70% following administration of a lumbar ESI (7-0-2015) interlaminarly at L4-5. He reports that over the last week his condition has started to deteriorate with increased frequency and severity of radicular complaints to the left lower extremity. Objective findings included tenderness upon palpation midline at the level of the iliac crest as well as the left lumbosacral junction and left buttock. Pain, numbness and tingling are localized to the left L5 dermatome. Work status was documented as "per primary treating physician." The plan of care included, and authorization was requested for preoperative laboratory works and medical clearance and a 2nd lumbar interlaminar epidural steroid injection at center L4-5 levels. On 9-11-2015 Utilization Review non-certified the request for preoperative laboratory works and medical clearance and one right lumbar interlaminar epidural steroid injection at center L4-5 levels.

IMR ISSUES, DECISIONS AND RATIONALES

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

One (1) pre-operative laboratory works (Prothrombin time, partial Prothrombin time): 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), Preoperative lab testing.

Decision rationale: The claimant sustained a work injury in August 2013 as the result of a rear end motor vehicle accident. He was seen for an initial evaluation by the requesting provider in April 2015. Treatments had included physical therapy and medications. Epidural injections had been planned but had not been performed. He was having back pain radiating into the left leg. Review of systems was negative for hematologic abnormality and medications were ibuprofen and Lisinopril. An MRI of the lumbar spine is referenced as showing L4/5 degenerative spondylolisthesis with canal stenosis. He underwent an interlaminar epidural injection in July 2015. The epidural steroid injection was complicated and required a right-sided approach. When seen, there had been a 70% improvement after the injection. Over the previous week his condition had started to deteriorate and he had increased frequency and severity of left lower extremity radicular complaints. Physical examination findings included a mild limp favoring the left lower extremity. There was iliac crest and left lumbosacral junction and buttock tenderness. Straight leg raising was positive bilaterally. There were no strength or sensory deficits. Authorization was requested for a second epidural injection with pre-injection clearance and lab testing. He had undergone clearance prior to the first injection which included normal PT/PTT. The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings. In this case, the claimant has no history of bleeding disorder and is not taking any anticoagulant medication. The PT/PTT testing already performed was not medically necessary and repeat testing would not be medically necessary.

One (1) medical clearance: 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 Guidelines for pre-operative cardiac risk assessment and perioperative cardiac management in non-cardiac surgery. The Task Force for Preoperative Cardiac Risk Assessment and Perioperative Cardiac Management in Non-cardiac Surgery of the European Society of Cardiology (ESC) and endorsed by the European Society of Anesthesiology (ESA). European Heart Journal (2009) 30, 2769.

Decision rationale: The claimant sustained a work injury in August 2013 as the result of a rear end motor vehicle accident. He was seen for an initial evaluation by the requesting provider in

April 2015. Treatments had included physical therapy and medications. Epidural injections had been planned but had not been performed. He was having back pain radiating into the left leg. Review of systems was negative for hematologic abnormality and medications were ibuprofen and Lisinopril. An MRI of the lumbar spine is referenced as showing L4/5 degenerative spondylolisthesis with canal stenosis. He underwent an interlaminar epidural injection in July 2015. The epidural steroid injection was complicated and required a right-sided approach. When seen, there had been a 70% improvement after the injection. Over the previous week his condition had started to deteriorate and he had increased frequency and severity of left lower extremity radicular complaints. Physical examination findings included a mild limp favoring the left lower extremity. There was iliac crest and left lumbosacral junction and buttock tenderness. Straight leg raising was positive bilaterally. There were no strength or sensory deficits. Authorization was requested for a second epidural injection with pre-injection clearance and lab testing. He had undergone clearance prior to the first injection which included normal PT/PTT. Surgical interventions can be divided into low-risk, intermediate-risk, and high-risk groups. In this case, a low risk procedure is being requested and there are no identified significant co-morbid conditions identified. The medical clearance already provided was not medically necessary and repeat clearance would not be medically necessary.

One (1) right interlaminar lumbar epidural steroid injection at Center L4-L5 levels: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back-Lumbar & Thoracic (Acute & Chronic) Epidural steroid injections (ESIs), therapeutic.

Decision rationale: The claimant sustained a work injury in August 2013 as the result of a rear end motor vehicle accident. He was seen for an initial evaluation by the requesting provider in April 2015. Treatments had included physical therapy and medications. Epidural injections had been planned but had not been performed. He was having back pain radiating into the left leg. Review of systems was negative for hematologic abnormality and medications were ibuprofen and Lisinopril. An MRI of the lumbar spine is referenced as showing L4/5 degenerative spondylolisthesis with canal stenosis. He underwent an interlaminar epidural injection in July 2015. The epidural steroid injection was complicated and required a right-sided approach. When seen, there had been a 70% improvement after the injection. Over the previous week his condition had started to deteriorate and he had increased frequency and severity of left lower extremity radicular complaints. Physical examination findings included a mild limp favoring the left lower extremity. There was iliac crest and left lumbosacral junction and buttock tenderness. Straight leg raising was positive bilaterally. There were no strength or sensory deficits. Authorization was requested for a second epidural injection with pre-injection clearance and lab testing. He had undergone clearance prior to the first injection which included normal PT/PTT. In terms of lumbar epidural steroid injections, guidelines recommend that, in the diagnostic

phase, a maximum of two injections should be performed. A repeat block is not recommended if there is inadequate response to the first block. A second block is also not indicated if the first block is accurately placed unless there is a question of the pain generator, there was possibility of inaccurate placement, or there is evidence of multilevel pathology. In these cases a different level or approach might be proposed. There should be an interval of at least one to two weeks between injections. In this case, the claimant had a positive response to the injection performed previously. He has radicular symptoms with positive neural tension sign and left lower extremity weakness manifesting as a limp without reported antalgia. A second diagnostic injection would determine whether further therapeutic injections, if requested, would be indicated. The rationale for a right-sided approach is clear. The request is medically necessary.