

Case Number:	CM15-0021551		
Date Assigned:	02/11/2015	Date of Injury:	10/28/2008
Decision Date:	03/25/2015	UR Denial Date:	02/02/2015
Priority:	Standard	Application Received:	02/04/2015

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: Arizona, California

Certification(s)/Specialty: Family Practice

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 58 year old male, who sustained an industrial injury on 10/28/2008, sustaining an injury to his knee and back. The diagnoses have included chronic pain syndrome, lumbar post laminectomy syndrome, bilateral knee pain, carpal tunnel syndrome, diabetes, and depressive disorder. Treatment to date has included surgical interventions and conservative treatments. Currently, the injured worker complains of neck pain with radiation to the right upper extremity, with numbness, tingling, and weakness. He also reported low back pain with radiation to the right anterior leg, with some burning pain and weakness. He reported significant numbness to bilateral lower extremities, impacting his driving and getting around. He requested that his driving be adapted so that he could drive with his hands. He also requested a lift chair for assisted mobility. He did have a scooter but it was too big to fit in his house. Current medications included Fentanyl, Oxycontin, Lyrica, Baclofen, Gabapentin, and Ketamine cream. Pain levels were 10/10 without medication and 8-9/10 with medication. Tenderness was noted in the paracervical muscles and decreased range of motion was noted. Sensation was decreased in the right lateral arm and strength was 5-/5, left 5/5. Tenderness was noted in the paraspinal muscles of the lower lumbar spine and range of motion was decreased. Reflexes of the patellar were trace and the Achilles absent. Right lower extremity strength was 5-/5, left 5/5, though he had decreased dorsiflexion of the right foot and was wearing a brace. Decreased sensation was noted to both lower extremities, right greater than left. Straight leg raise test was positive on the right and gait was antalgic, using a cane. Magnetic resonance imaging of the cervical spine (4/04/2012) was referenced as including findings of C6-7 right-sided disc osteophyte with spinal

canal bilateral foraminal restriction. A progress note on 1/20/15 indicated the physician is planning on referring the claimant for a lumbar and cervical fusion but the claimant has deferred it. On 2/02/2015, Utilization Review (UR) non-certified a request for interlaminar epidural steroid injection at C6-7, noting the lack of compliance with MTUS Chronic Pain Medical Treatment Guidelines, non-certified a request for a lift chair, citing Non-MTUS Guidelines, and non-certified a request for adaptation of a vehicle for hand driving, citing Non-MTUS Guidelines.

IMR ISSUES, DECISIONS AND RATIONALES

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

Interlaminar Epidural Steroid Injection (ESI) C6-7: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 8 Neck and Upper Back Complaints Page(s): 174-175, Chronic Pain Treatment Guidelines Epidural injections Page(s): 46.

Decision rationale: According to the MTUS guidelines, epidural injection is recommended as an option. Criteria is as follows: The purpose of ESI is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit.1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). 3) Injections should be performed using fluoroscopy (live x-ray) for guidance. 4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections. 5) No more than two nerve root levels should be injected using transforaminal blocks. 6) No more than one interlaminar level should be injected at one session. 7) 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. 8) Current research does not support series-of-three injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections. According to the ACOEM guidelines, epidural steroid injections are not recommended. Invasive techniques are of questionable merit. The treatments do not provide any long-term functional benefit or reduce the need for surgery. In this case, there was a plan for surgery but delayed due to claimant's fear. Since the injections are not lasting, they will likely lead to an eventual need for surgery. In addition, recent exam findings do not indicate abnormal neurological findings. The request for Cervical Epidural Steroid Injections is not medically necessary.

Lift chair: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Physical Medicine & Rehabilitation, Principles and Practice. Ed. DeLisa, JA. 4th Ed, Lipincott. 2006. Chapt. 60, Assistive Technology, page 1309

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Powered Mobility Devices- Knee Chapter

Decision rationale: According to the guidelines are 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. In this case, the claimant had right upper extremity weakness and bilateral lower extremity weakness. As a result, the need for powered wheelchair and lift chair are medically necessary.

Adaptation of vehicle for hand driving: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Physical Medicine & Rehabilitation, Principles and Practice. Ed. DeLisa, JA. 4th Ed, Lipincott. 2006. Chapt. 60, Assistive Technology, page 1309

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Powered Mobility Devices- Knee Pain Chapter

Decision rationale: According to the guidelines are 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. In this case, the claimant had right upper extremity weakness and bilateral lower extremity weakness with decreased range of motion. However, the use of a vehicle is not considered durable medical equipment and not considered a necessity. As a result, the request for a vehicle adaptation for driving is not medically necessary.