

Case Number:	CM15-0213789		
Date Assigned:	11/03/2015	Date of Injury:	03/03/1983
Decision Date:	12/15/2015	UR Denial Date:	10/21/2015
Priority:	Standard	Application Received:	10/30/2015

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: North Carolina
 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 61-year-old male, with a reported date of injury of 08-21-2007. The diagnoses include lumbosacral intervertebral disc degeneration, and lumbosacral spinal stenosis. The progress note dated 10-02-2015 indicates that the injured worker's pain level had remained unchanged since the last visit. He rated his pain 5 out of 10 with medications and 7 out of 10 without medications. It was noted that an MRI of the lumbar spine on 09-18-2008 showed spondylolisthesis and anterolisthesis of L5 upon S1 with bilateral foraminal narrowing, degenerative disc disease at L1-2, and L4-5, and multilevel degenerative disc disease. The objective findings include normal lordosis with straightening of the lumbar spine; restricted range of motion of the lumbar spine with flexion limited to 60 degrees due to pain and extension limited to 10 degrees due to pain; positive bilateral lumbar facet loading; negative straight leg raise test; and decreased sensation to light touch over the medial foot on both sides. The injured worker's work status was deferred to the primary treating physician. The diagnostic studies to date have included a urine drug screen on 10-02-2015 with inconsistent findings for Clonazepam and caffeine. Treatments and evaluation to date have included Celebrex, Lidocaine patch, Toprol, and twelve acupuncture visits. The treating physician requested an MRI of the lumbar spine, transforaminal lumbar epidural steroid injection at L5, and referral to an orthopedic surgeon. The treating physician indicated that the injured worker noted that he had experienced an increase in leg pain, left greater than right, radiating down the back of his leg and knee. He stated that his toes were becoming more painful; and that the pain was increasing. The injured worker wanted to consider the possibility of surgery. On 10-21-2015, Utilization

Review (UR) non-certified the request for an MRI of the lumbar spine, transforaminal lumbar epidural steroid injection at L5, and referral to an orthopedic surgeon.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the lumbar spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Special Studies.

Decision rationale: The ACOEM chapter on low back complaints and special diagnostic studies states: Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computed tomography [CT] for bony structures). Relying solely on imaging studies to evaluate the source of low back and related symptoms carries a significant risk of diagnostic confusion (false positive test results) because of the possibility of identifying a finding that was present before symptoms began and therefore has no temporal association with the symptoms. Techniques vary in their abilities to define abnormalities (Table 12-7). Imaging studies should be reserved for cases in which surgery is considered or red-flag diagnoses are being evaluated. Because the overall false-positive rate is 30% for imaging studies in patients over age 30 who do not have symptoms, the risk of diagnostic confusion is great. There is no recorded presence of emerging red flags on the physical exam. There is evidence of nerve compromise on physical exam but there is not mention of consideration for surgery or complete failure of conservative therapy. For these reasons, criteria for imaging as defined above per the ACOEM have not been met. Therefore the request is not medically necessary.

Transforaminal lumbar epidural injection L5: Upheld

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 rationale: The California chronic pain medical treatment guidelines section on epidural steroid injections (ESI) states: Criteria for the use of Epidural steroid injections: Note: 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 percent 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 (Manchikanti, 2003), (CMS, 2004), (Boswell, 2007). 8) Current research does not support a series-of-three injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections. The patient has the documentation of back pain however there is no included imaging or nerve conduction studies in the clinical documentation provided for review that corroborates dermatomal radiculopathy found on exam for the requested level of ESI. Therefore criteria have not been met and the request is not medically necessary.

Referral to orthopedic surgeon: Overturned

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

MAXIMUS guideline: Decision based on MTUS General Approaches 2004, Section(s): General Approach to Initial Assessment and Documentation, Initial Approaches to Treatment.

Decision rationale: Per the ACOEM: The health practitioner may refer to other specialist if a diagnosis is uncertain or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise. A referral may be for 1. Consultation to aid in the diagnosis, prognosis, therapeutic management, determination of medical stability. The patient does not have a documented continued back pain that has failed to respond to the prescribe therapy. Therefore criteria for an orthopedic consult has been met and the request is medically necessary.