

Case Number:	CM15-0039101		
Date Assigned:	03/09/2015	Date of Injury:	08/10/2004
Decision Date:	04/16/2015	UR Denial Date:	02/13/2015
Priority:	Standard	Application Received:	03/02/2015

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: New York, Tennessee
 Certification(s)/Specialty: Emergency Medicine

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 57-year-old female, who sustained an industrial injury on 8/10/2004. She was diagnosed as having cervical discopathy with disc displacement, cervical radiculopathy, lumbar discopathy with disc displacement and lumbar radiculopathy. Treatment to date has included medications and modified work status. Per the Primary Treating Physician's Progress Report dated 12/06/2014, the injured worker reported low back pain with radiation to both legs associated with numbness and tingling in both legs. The symptoms are more intense on the right side. She uses a front wheel walker to ambulate. Physical examination revealed tenderness to palpation over the cervical and lumbar paraspinal musculature. There is decreased range of motion secondary to pain and stiffness. Spurling's test is positive bilaterally. Supine straight leg raise test is positive at 20 degrees in the bilateral lower extremities, right greater than left. The plan of care included continuation of prescribed medications and compound creams. Authorization was requested for epidural steroid injections to C5 and C6, a home health care evaluation, Norco 10/325mg #120, a pain management consultation, right L4-5 microdiscectomy and Ultram ER 150mg #90 on 12/06/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right L4-L5 and L5-S1 microdiscectomy: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) and Other Medical Treatment Guidelines Official Disability Guidelines: Low back- Thoracic and Lumbar, Microdiscectomy, Discectomy/ laminectomy.

Decision rationale: Symptoms/Findings, which confirm presence of radiculopathy. Objective findings on examination need to be present. Straight leg raising test, crossed straight leg raising and reflex exams should correlate with symptoms and imaging. Findings require ONE of the following: A. L3 nerve root compression, requiring ONE of the following: 1. Severe unilateral quadriceps weakness/mild atrophy 2. Mild-to-moderate unilateral quadriceps weakness 3. Unilateral hip/thigh/knee pain B. L4 nerve root compression, requiring ONE of the following: 1. Severe unilateral quadriceps/anterior tibialis weakness/mild atrophy 2. Mild-to-moderate unilateral quadriceps/anterior tibialis weakness 3. Unilateral hip/thigh/knee/medial pain C. L5 nerve root compression, requiring ONE of the following: 1. Severe unilateral foot/toe/dorsiflexor weakness/mild atrophy 2. Mild-to-moderate foot/toe/dorsiflexor weakness 3. Unilateral hip/lateral thigh/knee pain D. S1 nerve root compression, requiring ONE of the following: 1. Severe unilateral foot/toe/plantar flexor/hamstring weakness/atrophy 2. Moderate unilateral foot/toe/plantar flexor/hamstring weakness 3. Unilateral buttock/posterior thigh/calf pain (EMGs are optional to obtain unequivocal evidence of radiculopathy but not necessary if radiculopathy is already clinically obvious.)II. Imaging Studies, requiring ONE of the following, for concordance between radicular findings on radiologic evaluation and physical exam findings: A. Nerve root compression (L3, L4, L5, or S1) B. Lateral disc rupture C. Lateral recess stenosis Diagnostic imaging modalities, requiring ONE of the following: 1. MR imaging 2. CT scanning 3. Myelography 4. CT myelography & X-RayIII. Conservative Treatments, requiring ALL of the following: A. Activity modification (not bed rest) after patient education (\geq 2 months) B. Drug therapy, requiring at least ONE of the following: 1. NSAID drug therapy 2. Other analgesic therapy 3. Muscle relaxants 4. Epidural Steroid Injection (ESI) C. Support provider referral, requiring at least ONE of the following (in order of priority): 1. Physical therapy (teach home exercise/stretching) 2. Manual therapy (chiropractor or massage therapist) 3. Psychological screening that could affect surgical outcome 4. Back school. In this case there is no documentation in the medical record of objective evidence of radiculopathy. There is no muscle weakness. Microdiscectomy is not indicated. The request should not be authorized.

Home health care evaluation for aide to assist in daily living post-operative for six weeks, eight hours per day: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 51.

Decision rationale: Chronic Pain Medical Treatment Guidelines state that home health services are recommended only for recommended medical treatment in patients who are homebound, on a part-time or "intermittent" basis, generally up to no more than 35 hours per week. Medical treatment does not include personal care like bathing, dressing, or toileting and it does not include homemaker services like shopping, laundry, or cleaning. The care requested in this case included laundry, shopping, and cleaning. These services are not covered. The request should not be authorized.

Pain Management consultation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management Page(s): 80.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 46. Decision based on Non-MTUS Citation UpToDate; Evaluation of Chronic Pain in Adults.

Decision rationale: Many patients with chronic pain may be managed without specialty referral. Patients may require referral to a pain specialist for the following reasons: Symptoms that are debilitating, Symptoms located at multiple sites, Symptoms that do not respond to initial therapies, Escalating need for pain medication. In this case the pain consultation is for cervical epidural steroid injection. Epidural steroid injections are recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). Most current guidelines recommend no more than 2 ESI injections. Current recommendations suggest a second epidural injection if partial success is produced with the first injection and a third ESI is rarely recommended. Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. There is little information on improved function. The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months, and there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain. Cervical epidural steroid injections are not recommended. The request should not be authorized.

Ultram ER (Tramadol HCL) 150 mg, thirty count: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 78, 82.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Pain Interventions and Guidelines Page(s): 74-96.

Decision rationale: Ultram is the opioid medication tramadol. Tramadol is a synthetic opioid affecting the central nervous system. It has several side effects, which include increasing the risk of seizure in patients taking SSRI's, TCA's and other opioids. Chronic Pain Medical Treatment

Guidelines state that opioids are not recommended as a first line therapy. Opioid should be part of a treatment plan specific for the patient and should follow criteria for use. Criteria for use include establishment of a treatment plan, determination if pain is nociceptive or neuropathic, failure of pain relief with non-opioid analgesics, setting of specific functional goals, and opioid contract with agreement for random drug testing. If analgesia is not obtained, opioids should be discontinued. The patient should be screened for likelihood that he or she could be weaned from the opioids if there is no improvement in pain or function. It is recommended for short-term use if first-line options, such as acetaminophen or NSAIDs have failed. In this case the patient has been receiving since at least and has not obtained analgesia. Criteria for long-term opioid use have not been met. The request should not be authorized.