

Case Number:	CM14-0155489		
Date Assigned:	09/25/2014	Date of Injury:	12/16/1999
Decision Date:	10/27/2014	UR Denial Date:	09/16/2014
Priority:	Standard	Application Received:	09/23/2014

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. The expert reviewer is Board Certified in Internal Medicine and is licensed to practice in California and Illinois. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 67-year-old male, who reported injury on 12/16/1999; reportedly, while the injured worker was lifting a cadaver that weighed 350 pounds, the injured worker was trying to have it fall on a gurney; the gurney collapsed, and the injured worker felt instant pain in his neck shooting down his back. The injured worker's treatment history included 3 level fusion cervical spine surgeries, epidural steroid injections, EMG/NCV study, MRI studies, CT scans, and medications. On 12/06/2013, the injured worker had undergone a caudal epidural. In 01/2014, the injured worker had undergone an epidural injection and continued being with significantly elevated low back pain. The injured worker was evaluated on 08/13/2014, and it was documented that the injured worker complained of pain in and along the neck and lower back. He rated his pain as 7/10 on the pain scale. He reported pain occurs constantly. In addition to pain, he also complained of abnormal gait, back pain, myalgias, numbness, tingling, and weakness. The quality of sleep was poor. He was unable to perform any activities of daily living. He was unable to shower without supervision secondary to his unstableness and risk for falls. He was able to do most dressing and feeding of himself, but was not able to do any cooking or cleaning. Physical examination of the cervical spine revealed range of motion restricted with limited range of motion in all planes secondary to weakness. On examination of paravertebral muscles, spasm and tenderness was noted on both sides. Cervical facet tenderness, C2-6. Biceps reflex was 0/4 on both sides. Brachioradialis reflex was 0/4 on both sides. Lumbar spine examination revealed that L4-5 lumbar facet tenderness to palpation was noted. The injured worker can was able to walk on heels and can was able to walk on toes. Straight leg raising test was positive. Diagnoses included disc disorder lumbar, spinal lumbar disc degenerative disease, low back pain, and cervical facet syndrome, disc disorder cervical, and cervical radiculopathy. Request for Authorization was not submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Doppler ultrasound of the left lower extremity: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee and Leg, Venous Thrombosis, A.D.A.M. Medical Encyclopedia, Doppler Ultrasound Exam of an Arm or Leg, June 5, 2012

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Knee & Leg. Venous Thrombosis

Decision rationale: The request for Doppler Ultrasound of the left lower extremity is not medically necessary. Official Disability Guidelines (ODG) state patients who received aspirin had a lower VTE risk score than the patients who received warfarin. Patients who received aspirin had a much lower use of sequential compression devices than high-risk patients, but even aspirin patients should receive sequential compression as needed. Patients with suspected deep vein thrombosis (DVT) of the lower extremities are usually investigated with ultrasonography either by the proximal veins (2-point ultrasonography) or the entire deep vein system (whole-leg ultrasonography). The latter approach is thought to be better based on its ability to detect isolated calf vein thrombosis; however, it requires skilled operators and is mainly available only during working hours. These two ultrasound-based evaluations, both with their advantages and disadvantages, are about equally effective at guiding the management of patients with suspected lower-extremity deep-vein thrombosis (DVT), conclude the authors of a large RCT reported in JAMA. But the writer of an accompanying editorial gives the edge to one of the techniques (2-point ultrasonography), the one that's been around longer and is simpler and probably more widely available. However, the use of 2-point ultrasonography to diagnose DVT frequently requires repeated testing in 1 week to detect calf DVT, which can extend to the proximal veins. Whole-leg Doppler ultrasonography generally obviates this requirement, making 1-day testing possible. A systematic review looked at 5 types of interventions used to prevent thromboembolism in pelvic and acetabular fracture patients: mechanical compression devices, inferior vena cava filters, low-molecular weight heparins, ultrasound screening, and magnetic resonance venography screening. They concluded that there was limited data to guide which method to choose. There was no legible red flag indications that could be clearly understood to justify the request. The request for Doppler ultrasound of the left lower extremity is not medically necessary.

Lumbar epidural injection at bil L5-S1 vs caudal injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the Use of Epidural Steroid Injections Page(s): 46.

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

Decision rationale: The requested service is not medically necessary. The California Treatment Guidelines recommend epidural steroid injections as an option for treatment of radicular pain (defined as pain in dermatome distribution with corroborative findings of radiculopathy). 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. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electro diagnostic testing. Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). Additionally, failure to respond to conservative treatment is also a criterion for ESIs. There was lack of documentation of home exercise regimen and pain medication management or the outcome measurements for the injured worker. On examination, it was noted that the injured worker does not have findings of radiculopathy as required per the guidelines. It was documented the injured worker had undergone epidural steroid injections in the past. However, improvement outcome measures were not submitted for this review. As such, the request for lumbar epidural injection at bil L5-S1 vs caudal injection is not medically necessary.