MAXIMUS Federal Services

Case Number:	CM14-0168167		
Date Assigned:	10/15/2014	Date of Injury:	07/30/2001
Decision Date:	11/18/2014	UR Denial Date:	09/29/2014
Priority:	Standard	Application Received:	10/13/2014

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 Orthopedic Surgery and is licensed to practice in California. 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:

This is a 62-year-old male who sustained a vocational injury on 07/30/01 while loading a 55-gallon oil drum onto a truck. The medical records provided for review documented that the claimant had three lumbar spine surgeries to include laminectomy, foraminotomy, micro discectomy of the L4-5 and L5-S1 levels on 03/05/02, exploration surgery at L4-5 and L5-S1 on 07/09/02, and re-exploration surgery on 03/23/04. The report of an MRI of the lumbar spine without contrast dated 04/12/12 revealed postoperative changes of the lower lumbar spine with suggestion of herniated nerve roots through the laminotomy defect. There was epidural lipomatosis contributing to spinal canal narrowing of the lower lumbar spine. Degenerative changes were noted. An EMG study of the bilateral lower extremities dated 4/18/12 showed no active lumbar radiculopathy or evidence of entrapment neuropathy. The report of an MRI of the lumbar spine without contrast dated 07/07/14 identified the right L4-L5 hemilaminectomy. At the L5 level, there was herniation of the thecal sac and cauda equina nerve roots into the right hemilaminectomy defect and mild central clumping of the cauda equina nerve roots related to proximal stenosis or arachnoiditis. There were no suspicious fluid collections. There were prominent dorsal and ventral fat cells and mild to moderate L3-4 and L4-5 spinal canal stenosis. There was a combination of degenerative disc disease, facet arthropathy, and ligamentum flavum redundancy contributing to the mild to moderate bilateral L4-L5 and moderate bilateral L5-S1 neural foraminal stenosis. This caused deformity of the exiting bilateral L4 and L5 nerve roots. There was a moderate right L4-L5 lateral recess stenosis with compression of the transiting right L5 nerve root. There was a laterally directed disc and osteophyte disease contacting the exiting bilateral L5 nerve root in the extraforaminal zone. The office note dated 09/11/14 documented that there was no change in the claimant's condition since the previous visit. Physical examination showed range of motion was 10 to 25 degrees with decreased flexion/extension and

right bending with pain. He was noted to be wearing a brace which fit well. There was positive straight leg raise at 30 degrees on the right at the L5-S1 dermatomes of the calf; gait was slow with the assistance of a cane for balance. The claimant was noted to be unable to toe walk. The claimant was provided a diagnosis of L5-S1 degenerative disc disease, severe narrowing, disc herniation, and right greater than left radiculopathy of the L5 and S1 dermatomes. At the L4-5 level, he was noted to have degenerative disc disease with disc herniation status post a right laminectomy which has failed. He was also given a diagnosis of clumping of roots for arachnoiditis or proximal stenosis on the most recent MRI. The claimant was also diagnosed with lumbar neuritis, post laminectomy syndrome, lumbago, and pain in the joints of the lower legs. It was noted that a urine toxicology screen was performed to monitor the claimant's compliance with his pharmaceutical treatment regimen including controlled substances. However, the report from the urine drug screen or any documentation suggesting what the findings were was not available for review. The medical records document that the claimant is currently taking Norco 10/325 and Orphenadrine ER and that the claimant has tried Flector Patches. Documentation also suggests that the claimant had four acupuncture sessions in 2009 and has been wearing a lumbar brace since 2010. It was documented that the claimant attended nine out of twelve physical therapy sessions in 2012.

IMR ISSUES, DECISIONS AND RATIONALES

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

L5-S1 ESI with facet x2 with monitored anesthesia care: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300,Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs). Decision based on Non-MTUS Citation Official Disability Guidelines, Lumbar Spine

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs) Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG); Low Back chapter: Facet joint injections, multiple series.

Decision rationale: The California Chronic Pain Medical Treatment Guidelines recommend that prior to considering epidural steroid injections, there should be documentation of radiculopathy on physical examination and corroborated by imaging studies and/or electrodiagnostic testing. The claimant should be initially unresponsive to conservative treatment to include exercise, physical methods, anti-inflammatories, and muscle relaxants. A multiple series of facet injections is not recommended per Official Disability Guidelines. No more than one therapeutic intra-articular block is recommended for facet injections. Prior to considering additional injections, there should be documentation supporting an initial pain relief of 70 percent plus pain relief of at least 50 percent for a duration of at least six weeks. No more than two joint levels should be injected at any one time. Given the fact that the current request is for two facet joint blocks, the request cannot be considered medically necessary based on Official Disability Guidelines. No more than one therapeutic intra-articular block is recommended. In addition, documentation suggests that the blocks are to be performed together. It is not understood how the physician would be able to determine the greatest pain generator to focus additional treatment on by performing an epidural steroid injection along with a facet injection at the same time.

Facet injections are not recommended in the setting of radiculopathy which appears to be clearly present at least on subjective complaints and abnormal physical objective findings. Based on the documentation presented for review and in accordance with California Chronic Pain Treatment Guidelines as well as Official Disability Guidelines, the request for the L5-S1 epidural steroid injection with facet injection times two cannot be considered medically necessary.

Post-op physical therapy 3x3: 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): Physical therapy (PT)

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

UA: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines UDS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Drug testing,Opioids Page(s): 43;76-77,85,89 and 94.

Decision rationale: Documentation suggests that a urine drug screen was performed on 09/11/14. Prior to considering the medical necessity for an additional urinalysis, it would be imperative to know the results of the 09/11/14 urine drug screen prior to considering further drug screenings. Based on the documentation presented for review and in accordance with California Chronic Pain Medical Treatment Guidelines, the request for the urinalysis cannot be considered medically necessary.