

Case Number:	CM14-0023655		
Date Assigned:	05/12/2014	Date of Injury:	12/31/2012
Decision Date:	08/15/2014	UR Denial Date:	01/28/2014
Priority:	Standard	Application Received:	02/24/2014

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 Physical Medicine & Rehabilitation, has a subspecialty in Pain Medicine 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:

The patient is a 53-year-old female with a 12/31/12 date of injury. Diagnosis includes discogenic degeneration of the lumbar spine; muscle injury; muscle spasm; hypertension; insomnia; shift somnolence; lumbar facet arthropathy; lumbar nerve root injury; and gastritis. Progress note dated 12/11/13 documented that the patient received prior blocks, which resulted in improvement. However, she has severe back pain, which radiates to the bilateral legs, worse on left. 12/20/13 progress report described short-term improvement from prior lumbar epidural injections. There is ongoing severe low back pain with radiation to the bilateral legs; pain with extension of the lumbar spine. It was noted the patient has a new injury that is causing more pain than would be expected from a flare up of the old injury. There was left leg radicular pain in the left L4 distribution. Recent ESI relieved some of the L3 and L5 radicular pain. Clinically there is reduced range of motion lumbar spine; positive SLR bilaterally; pain and muscle spasms of the left L4 level. Lumbar ESI and lumbar facet blocks at L4-5 were requested. 4/21/14 followup stated that the patient requires a refill of Duragesic and Dilaudid. Medications are utilized for control pain. The requesting provider noted that the MRI of the lumbar spine revealed significant disc bulging, however the radiologist reported minimal disc bulging. It was noted that the patient has ongoing low back and radicular pain on the left, which has been increasing. Facet injections on the left were requested, as well as left L4 segmental nerve root blocks. It was noted that the patient improved in the past with ESI and segmental nerve root blocks. 4/28/14 progress note described ongoing low back pain. The patient was unable to go to work. Injections or surgery were recommended.

IMR ISSUES, DECISIONS AND RATIONALES

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

L3, L4, L5, S1 LUMBAR EPIDURAL STEROID INJECTION WITH ANESTHESIA:

Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines EPIDURAL STEROID INJECTIONS (ESIs).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) and on the Other Medical Treatment Guideline or Medical Evidence: The AMA Guides define radiculopathy as a significant alteration in the function of a nerve root or nerve roots and is usually caused by pressure on one or several nerve roots.

Decision rationale: Medical necessity for the requested lumbar ESI at L3, L4, L5, and S1 is not established. The patient has had several injections in the past, however there is no specific description of the percent of pain relief or duration of pain relief. Guidelines require description of at least 50-70% pain relief for 6-8 weeks from prior injections, and no more than 4 blocks per region per year. In addition, no more than 2 nerve root levels should be injected at one time. This request previously obtained an adverse determination due to lack of documentation regarding extent and duration of pain relief. Within the context of this appeal, additional progress notes were provided, however there remains no specific description of the percent of pain relief or duration of pain relief from prior injections. The number of levels requested for injection exceeds guidelines recommendations. The request of ESI is not substantiated.

LABS: CBC, CHEM PANEL, PT, PTT, UA: 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) ODG Low Back Chapter.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) ODG Low Back Chapter.

Decision rationale: Medical necessity for the requested laboratory testing is not established. Laboratory testing was requested for preoperative evaluation, prior to the requested lumbar ESI. As the lumbar ESI was not found medically necessary, the associated request for laboratory testing is also not substantiated.

ELECTROCARDIOGRAM (EKG): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: ACC/AHA Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: ACC/AHA Clinical Competence Statement on Electrocardiography and Ambulatory Electrocardiography.

Decision rationale: Medical necessity for the requested electrocardiogram is not established. General medical practice makes it reasonable that patient's with known cardiovascular disease should undergo EKG to provide baseline evaluation, to follow the course of cardiovascular disease, and to evaluate treatment. The patient is known to have hypertension, however there is no clear clinical indication for the use of electrocardiogram. This request obtained an adverse determination in the past due to lack of supporting documentation indicating necessity of more extensive cardiovascular evaluation. Within the context of this appeal, no additional information was provided, including suspicion of cardiovascular damage. In fact the most recent ROS noted no history of high blood pressure, angina, SOB, or dyspnea. The request remains unsubstantiated.

CHEST X-RAY: 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).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pulmonary chapter; chest x-ray.

Decision rationale: Medical necessity for the requested chest x-ray is not established. This request previously obtained an adverse determination, as there was no documentation regarding utility of a chest x-ray. There was no description of any respiratory complaints including shortness of breath, chest pain or injury, fever, or a persistent cough. Within the context of this appeal, this issue was not addressed. ODG does not recommend chest x-rays in asymptomatic patients with unremarkable histories and physicals. The request is not substantiated.