

Case Number:	CM15-0023110		
Date Assigned:	02/12/2015	Date of Injury:	11/12/2008
Decision Date:	06/05/2015	UR Denial Date:	02/06/2015
Priority:	Standard	Application Received:	02/06/2015

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: Texas
 Certification(s)/Specialty: Orthopedic Surgery

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 36-year-old male, who sustained an industrial injury on 11/12/2008. He reported injures from motor vehicle accident. The injured worker was diagnosed as having post-traumatic headaches, cervical whiplash, thoracic whiplash, lumbar sprain with lower extremity radiculopathy and instability, bilateral upper extremity numbness and tingling, left shoulder labral tear status post debridement and reconstruction, post traumatic ADD with possible pre-existing component, anxiety, depression secondary to closed head injury, dizziness and balance impairment, and right olecranon contusion with possible neuroma. Treatment to date has included medications. The request is for transforaminal epidural steroid injection at L5, and S1, fluoroscopic guidance, moderate sedation services, right then left C3 radiofrequency ablation, right then left C4 radiofrequency ablation, fluoroscopic guidance, moderate sedation services, pool therapy, and surgical evaluation for fusion. On 1/26/2015, he complained low back pain. He reported his pain to be 9/10 on pain scale, and is taking 1-2 Vicodin daily. The treatment plan included epidural steroid injections, pool therapy, and Tramadol. The records indicate a 75% pain reduction with a previous radiofrequency ablation and prior epidural steroid injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral transforaminal epidural steroid injection at L5 - S1 with fluoroscopy under moderate sedation: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Epidural Steroid Injection, Sedation.

Decision rationale: The California MTUS Guidelines recommend repeat epidural steroid injections when there is documentation of objective functional improvement and an objective decrease in pain. The clinical documentation submitted for review indicated the injured worker had an improvement in function after the epidural steroid injection. However, there was a lack of documentation of an objective decrease in pain of at least 50%, an objective improvement in function and documentation of medication reduction for 6 to 8 weeks. The guidelines do not address sedation. As such, secondary guidelines were sought. The Official Disability Guidelines indicate that sedation is appropriate for injured workers who have documented issues of extreme anxiety. As the epidural is not supported, the request for moderate sedation is not supported. Given the above, the request for bilateral transforaminal epidural steroid injection at L5 - S1 with fluoroscopy under moderate sedation is not medically necessary.

Right then left C3 and C4 radiofrequency ablation with fluoroscopic guidance under moderate sedation: 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), web, Neck: Criteria for Use of Cervical Facet Radiofrequency Neurotomy.

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

Decision rationale: The Official Disability Guidelines recommends for repeat neurotomies that the injured worker had documentation of duration of relief from the first procedure for at least 12 weeks at 50% relief. The current literature does not support that the procedure is successful without sustained pain relief (generally of at least 6 months duration). No more than 3 procedures should be performed in a year's period. Additionally, the approval of repeat neurotomies depends on variables such as evidence of adequate diagnostic blocks, documented improvement in VAS score, decreased medications and documented improvement in function. In addition, there should be a formal plan of additional evidence-based conservative care in addition to facet joint therapy. The clinical documentation submitted for review failed to indicate the injured worker had relief from the first procedure for at least 12 weeks. There was a lack of documentation of an improvement in VAS scores, decreased medications and improvement in function. There was a lack of documentation indicating there was a formal plan of additional evidence based conservative care in addition to the facet joint therapy. Given the above, the

request for Right then left C3 and C4 radiofrequency ablation with fluoroscopic guidance under moderate sedation is not medically necessary.

Pool therapy 2 times a week for 3 weeks: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic Therapy Page(s): 22.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Aquatic Therapy, Physical Medicine Page(s): 22, 98, 99.

Decision rationale: The California MTUS guidelines recommend aquatic therapy as an optional form of exercise therapy that is specifically recommended where reduced weight bearing is desirable. The guidelines indicate the treatment for Myalgia, myositis is 9-10 visits, and for Neuralgia, neuritis, and radiculitis, it is 8-10 visits. The clinical documentation submitted for review failed to indicate the injured worker had a need for reduced weight bearing. The prior therapies were not provided. There was a lack of documentation of objective deficits. The request as submitted failed to indicate the body part to be treated. Given the above, the request for pool therapy 2 times a week for 3 weeks is not medically necessary.

Surgical evaluation for fusion: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Medical Treatment Utilization Schedule (MTUS) American College of Occupational and Environmental Medicine (ACOEM), Chapter 12, web, Surgical Considerations.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 305-307.

Decision rationale: The American College of Occupational and Environmental Medicine indicate a surgical consultation may be appropriate for injured workers who have severe and disabling lower leg symptoms in a distribution consistent with abnormalities on imaging studies preferably with accompanying objective signs of neural compromise. There should be documentation of activity limitations due to radiating leg pain for more than 1 month or the extreme progression of lower leg symptoms, and clear clinical, imaging and electrophysiologic evidence of a lesion that has been shown to benefit in both the short and long term from surgical repair and documentation of a failure of conservative treatment to resolve disabling radicular symptoms. Additionally, there is no good evidence from controlled trials that spinal fusion alone is effective for treating any type of acute low back problem, in the absence of spinal fracture, dislocation, or spondylolisthesis if there is instability and motion in the segment operated on. Clinicians should consider referral for psychological screening to improve surgical outcomes. The clinical documentation submitted for review failed to provide an MRI and clear clinical documentation the injured worker had a necessity for a fusion and had spinal stenosis. There was a lack of documentation of a failure of conservative care. Given the above, the request for surgical evaluation for fusion is not medically necessary.

