

Case Number:	CM13-0015481		
Date Assigned:	05/21/2014	Date of Injury:	02/18/1999
Decision Date:	06/13/2014	UR Denial Date:	08/14/2013
Priority:	Standard	Application Received:	08/23/2013

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 and rehabilitation, has a subspecialty in Pediatric Rehabilitation Medicine, and is licensed to practice in Texas. 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 65-year-old who reported an injury on February 18, 1999. The mechanism of injury was not provided. The documentation of July 1, 2013 revealed the injured worker had complaints of previous pain rating of 9/10 on a good day and current pain rating of 10/10 on a bad day. The injured worker complained of weakness and spasms. It was indicated that the injured worker had lumbar surgery times 4 with no hardware. The injured worker had tenderness to palpation at L5-S1. The injured worker had pain and tenderness across the low back on extension and along the facet joint region. The injured worker had decreased sensation to the left lower extremity to light touch. The injured worker had normal sensation to pinprick in the upper and lower extremities and normal sensation to vibration. Muscle examination revealed that the injured worker had 4+/5 strength in the left extensor hallucis longus and plantar flexor. The reflex examination revealed 1+ reflexes in the left knee. The diagnoses included lumbar radiculopathy, lumbar facet arthropathy, lumbar degenerative disc disease and lumbar discogenic spine pain, and chronic pain. Treatment plan included a continuation of ibuprofen 600 mg tablets by mouth twice daily as needed, Norco 5/325 mg tablets 1 by mouth every four to six hours as needed, a home exercise program with warm heat and stretches. Additionally, a treatment request was made for bilateral L3, L4 and L5 transforminal injections. The injured worker had 50-60% pain relief for four to six months with a decreased usage of medication. The subsequent documentation of August 5, 2013 revealed the injured worker had increased radicular pain in the lower extremities since the last visit. The injured worker's physical examination remained the same. The injured worker was noted to be on levothyroxine. The treatment plan included a urinary tox screen and levothyroxine.

IMR ISSUES, DECISIONS AND RATIONALES

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

RIGHT LUMBAR TRANSFORAMINAL INJECTIONS AT L3, L4, L5: Upheld

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

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

Decision rationale: The Chronic Pain Medical Treatment Guidelines recommend, for repeat epidural steroid injection, there must be objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than four blocks per region per year. The patient was noted to have a prior ESI (epidural steroid injection) on March 19, 2013. The clinical documentation submitted for review indicated that the injured worker had 50-60% pain relief for 4-6 months with a decreased usage of medication. There was a lack of documentation indicating the level and laterality for the prior epidural steroid injection. The request for right lumbar transforaminal injections at L3, L4, L5 is not medically necessary or appropriate.

LEFT LUMBAR TRANSFORAMINAL INJECTIONS L3, L4, L5: Upheld

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

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

Decision rationale: The Chronic Pain Medical Treatment Guidelines recommend, for repeat epidural steroid injection, there must be objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. The patient was noted to have a prior ESI on March 19, 2013. The clinical documentation submitted for review indicated that the injured worker had 50-60% pain relief for 4-6 months with a decreased usage of medication. There was a lack of documentation indicating the level and laterality for the prior epidural steroid injection. The request for left lumbar transforaminal injections at L3, L4, L5 is not medically necessary or appropriate.

ANESTHESIA FOR LUMBAR INJECTIONS QTY: 2.00: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

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

RADIOLOGIC EXAM LUMBAR SPINE, MINIMUM 4 VIEWS QTY: 2.00: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-305.

Decision rationale: The Low Back Complaints Chapter of the ACOEM Practice Guidelines indicate that lumbar spine x-rays should not be performed in patients with low back pain in the absence of red flags for serious spinal pathology, even if the patient has pain that has persisted for at least six weeks. However, it may be appropriate when the physician believes it would aid in patient management. The clinical documentation submitted for review failed to provide a PR-2 and DWC Form RFA to provide the rationale for a radiologic exam of the lumbar spine. The request for radiologic exam lumbar spine, minimum four views, quantity of two, is not medically necessary or appropriate.

FLUROSCOPIC GUIDANCE: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

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

LEVOTHYROXINE SODIUM: 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 website Drugs.com.

Decision rationale: According to the website drugs.com, "Levothyroxine is a replacement for a hormone normally produced by your thyroid gland to regulate the body's energy and metabolism. Levothyroxine is given when the thyroid does not produce enough of this hormone on its own." The clinical documentation submitted for review failed to provide the documentation of recent laboratory studies to support the necessity for levothyroxine. As such the efficacy could not be established. The duration of the medication use could not be established through submitted documentation. The request as it is submitted failed to indicate the frequency, quantity and

strength for levothyroxine. The request for Levothyroxine Sodium is not medically necessary or appropriate.

ONE URINE DRUG SCREEN, PROVIDED ON AUGUST 5, 2013,: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Ongoing Management Page(s): 78.

Decision rationale: The Chronic Pain Medical Treatment Guidelines recommend urine drug screens for injured workers who have documented issues of abuse, addiction or poor pain control. The clinical documentation submitted for review failed to provide documentation to meet the above criteria. The retrospective request for one urine drug screen, provided on August 5, 2013, is not medically necessary or appropriate.