

Case Number:	CM13-0030075		
Date Assigned:	11/27/2013	Date of Injury:	12/14/1994
Decision Date:	02/14/2014	UR Denial Date:	09/13/2013
Priority:	Standard	Application Received:	09/25/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Anesthesiology and Pain Medicine and is licensed to practice in Florida. 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 physician 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 68-year-old female who reported an injury on 12/14/1994. The mechanism of injury was not provided within the medical records. The patient's care up until recently was not provided or discussed within the medical records. The patient currently has diagnoses of a lumbar herniated nucleus pulposus at an unspecified level, right sciatica, fibromyalgia, depression and anxiety, and another illegible diagnosis. The patient has a history of lumbar epidural steroid injections; however, there was no objective documentation regarding their effect. The most recent injection was received in 05/2013 with a reported "moderate improvement" of low back pain and radiculopathy. In the most recent clinical note, dated 08/12/2013, the patient is noted to have negative straight leg raises, multiple trigger points, and absent knee reflexes. It appears that information regarding the neurological status of the patient was intended; however, the comments are illegible. There was no other information submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right Lumbar Epidural Steroid Injection, 1st level (QTY 1): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation ODG Guidelines WEB

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

Decision rationale: The California MTUS/ACOEM Guidelines state that epidural steroid injections are intended to reduce pain and inflammation, restore range of motion, and facilitate progress in a more active treatment program. Criteria that must be met in order to receive an epidural steroid injection include: documentation of objective physical examination findings of radiculopathy that have been corroborated by imaging studies or electrodiagnostic testing; the patient must be initially unresponsive to conservative treatment; and repeat blocks should be based on continued objective documentation and functional improvement, including at least 50% pain relief with associated reduction of medication use for 6 to 8 weeks. The medical records submitted for review did not provide objective physical examination evidence of the presence of radiculopathy. Secondly, the therapy note dated 06/03/2013 stated that the patient had an overall decrease in pain of 50% after the injection but the clinical note dated 08/12/2013 reported only a moderate improvement of lower back and radicular pain. There was no submission of clinical notes that documented the patient's concurrent decrease in medication use, nor was there documentation available suggesting the pain relief endured 6 to 8 weeks. There was also no documentation of failed physical therapy and muscle relaxant use, nor were there imaging studies to corroborate the patient's complaints of radiculopathy. Due to the lack of this objective information, medical necessity has not been established. As such, the request for right lumbar epidural steroid injection, 1st level (QTY 1), is non-certified.

Right Lumbar Epidural Steroid Injection, additional level (QTY 1): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines Page(s): 46. Decision based on Non-MTUS Citation ODG Guidelines WEB

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

Decision rationale: The California MTUS/ACOEM Guidelines state that epidural steroid injections are intended to reduce pain and inflammation, restore range of motion, and facilitate progress in a more active treatment program. Criteria that must be met in order to receive an epidural steroid injection include: documentation of objective physical examination findings of radiculopathy that have been corroborated by imaging studies or electrodiagnostic testing; the patient must be initially unresponsive to conservative treatment; and repeat blocks should be based on continued objective documentation and functional improvement, including at least 50% pain relief with associated reduction of medication use for 6 to 8 weeks. The medical records submitted for review did not provide objective physical examination evidence of the presence of radiculopathy. Secondly, the therapy note dated 06/03/2013 stated that the patient had an overall decrease in pain of 50% after the injection but the clinical note dated 08/12/2013 reported only a moderate improvement of lower back and radicular pain. There was no submission of clinical notes that documented the patient's concurrent decrease in medication use, nor was there documentation available suggesting the pain relief endured 6 to 8 weeks. There was also no documentation of failed physical therapy and muscle relaxant use, nor were there imaging studies to corroborate the patient's complaints of radiculopathy. Due to the lack of this objective

information, medical necessity has not been established. As such, the request for right lumbar epidural steroid injection, additional level (QTY 1), is non-certified.

Epidurography (QTY 1): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Center for Diagnostic Imaging (CDI), Diagnostic Epidurography, and a study titled Epidurography and Therapeutic Epidural Injections: Technical Considerations and Experience with 5334 Cases.

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

Decision rationale: As the patient does not currently meet guideline recommendations to receive an epidural steroid injection, the epidurography is not warranted at this time. Therefore, the request for epidurography (QTY 1) is non-certified.

Fluoroscopy guidance (QTY 1): Upheld

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

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

Decision rationale: As the patient does not currently meet guideline recommendations to receive an epidural steroid injection, fluoroscopy guidance is not warranted at this time. Therefore, the request for fluoroscopy guidance (QTY 1) is non-certified.

Voltaren Gel - apply up to 4 times daily (QTY 1): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): s 111-113. Decision based on Non-MTUS Citation ODG Web; 2004: chronic pain - Voltaren® Gel (diclofenac) and Topical analgesics.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Topical Analgesics Page(s): s 111-112.

Decision rationale: The California MTUS/ACOEM Guidelines recommend the use of non-steroidal anti-inflammatory agents in their topical formulation for short-term use only. However, guidelines state that topical NSAIDs are only effective in treating osteoarthritis of the knee, elbow, or other joints, and there is no evidence to support its use in the treatment of the spine, hip or shoulder. Although Voltaren gel is the only topical NSAID currently approved for use, there is no indication in the request as to which body part will be receiving this medication. Without this information, guideline compliance and medical necessity cannot be determined. As such, the request for Voltaren gel applied up to 4 times daily (QTY 1) is non-certified.

