

Case Number:	CM13-0033851		
Date Assigned:	12/06/2013	Date of Injury:	01/18/2001
Decision Date:	03/26/2014	UR Denial Date:	09/09/2013
Priority:	Standard	Application Received:	10/10/2013

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 Pain Management, has a subspecialty in Disability Evaluation and is licensed to practice in California, District of Columbia, Florida, and Maryland. 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 61-year-old female who reported injury on 01/18/2001. The patient has a long history of being treated for chronic low back pain and leg pain. The patient was noted to have undergone multiple imaging studies. Official studies included for this review were official MRI of the lumbar spine conducted on 11/29/2012 by [REDACTED] that revealed: (1) Spondylitic changes. (2) At L 1-2, a 1 mm to 2 mm posterior disc bulge without evidence of canal stenosis or neural foramina! Narrowing was noted. (3) At L2-3, a 1 mm to 2 mm posterior disc bulge without evidence of canal stenosis or neural foramina! narrowing was noted. (4) At L3-4, a 1 mm to 2 mm posterior disc bulge without evidence of canal stenosis or neural foramina I narrowing was noted. (5) At L5-S1. there was a 1 mm to 2 mm posterior disc bulge without evidence of canal stenosis or neural foraminal narrowing. Official MRI of the right knee was conducted on 12/06/2012 by [REDACTED] that revealed: (1) Globular increased signal intensity posterior horn of the medial meniscus most consistent with intrasubstance degeneration. Tear was not excluded. If clinically indicated, recommend MR arthrogram for further evaluation. (2) Radial tear anterior horn of the lateral meniscus. (3) Joint effusion. Official electrodiagnostic study was conducted on 07/17/2013 by [REDACTED]. Findings revealed EMG testing of the bilateral lower extremities and lumbosacral paraspinal muscles showed findings indicative of right L4-5 nerve root irritation. There was no evidence of entrapment neuropathy or peripheral neuropathy noted. Urine drug screen was conducted on 03/12/2013 by [REDACTED]. Findings did reveal inconsistent with prescription therapy. Carisoprodol/meprobamate was detected. This medication was not reported as prescribed. Consistent findings with prescription therapy included opioids reported as preliminarily positive with hydrocodone. Hydromorphone was also reported as prescribed and did have consistent

findings. The most recent clinical exam dated 06/13/2013 by [REDACTED] stated the patient was seen for a follow-up examination continuing to complain of low back pain which was constant and referral to the right leg which was intermittent. The patient stated she had been feeling a lot of anxiety lately and was getting to the point that she had shortness of breath. The patient rated her pain 6/10 to 7/10 with an average of 7/10 for the past one week. The patient reported a pain score with medication to be 6/10 to 7/10 and without medication 8/10 to 9/10. A urine drug screen was reportedly conducted on 05/24/2013 that was positive for soma, hydrocodone, hydromorphone, and ranitidine. Negative findings were reported Oxy. Authorization was requested for a urine drug screen, begin gaba-calm 1 sl 3 times daily for anxiety, continue Anaprox OS 550 mg to take by mouth 3 times daily for inflammation and pain, refill Norco 7.5/35 mg 1 by mouth every 6 hours for severe pain, continue Axid 150 mg one by mouth daily for gastric reflux, continue CytoFiex 2 by mouth in the morning and one by mouth in the evening for inflammation, pain and joint health, continue Medrox patch 1 topical application to the affected lumbar spine and the knee every 12 hours, refill soma 350 mg 1 by mouth every 12 hours, and re-request authorization for lumbar epidural steroid injection with epidurogram x1 and re-evaluation. At issue for lack of medical necessity is the Prospective Request for one Lumbar Spine Epidural Steroid Injection with Epidurogram between 8/9/13 and 11/2/13

IMR ISSUES, DECISIONS AND RATIONALES

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

Prospective Request for one Lumbar Spine Epidural Steroid Injection with Epidurogram between 8/9/13 and 11/2/13: Upheld

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

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

Decision rationale: Prospective Request for one Lumbar Spine Epidural Steroid Injection with Epidurogram between 8/9/13 and 11/2/13. Both CA-MTUS and ODG-TWC indicated that epidural steroid injections are recommended as an option for treatment of radicular pain. Radiculopathy should be documented by physical examination and corroborated by imaging findings. The patient should be initially unresponsive to conservative treatment including exercises, physical methods, NSAIDs, and muscle relaxants. In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least a 50% pain relief with associated reduction in medication use for 6 to 8 weeks, with a general recommendation of no more than 4 blocks per region per year. The records do not document how many lumbar epidural steroid injections the employee has already undergone in the past 2 years, the dates the injections were performed, or subjective/objective findings which would indicate their effect on the employee's pain level. The request for 1 lumbar spine epidural steroid injection with epidurogram is not medically necessary and appropriate.