

Case Number:	CM13-0051117		
Date Assigned:	12/27/2013	Date of Injury:	12/27/2001
Decision Date:	03/11/2014	UR Denial Date:	10/11/2013
Priority:	Standard	Application Received:	11/14/2013

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, has a subspecialty in Pain Management 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 57-year-old female who reported an injury on 12/27/2001. The patient is diagnosed with low back pain, lumbar facet arthropathy, lumbar disc displacement, lumbar disc degeneration, lumbar radiculopathy, sciatica, sacroiliac joint arthropathy, and trochanteric bursitis of the right hip. The patient was seen by [REDACTED] on 09/06/2013. The patient reported ongoing pain with activity limitation. The physical examination revealed tenderness to palpation in the lumbar spine, right lower extremity discomfort, diminished strength, and positive straight leg raising. The patient also demonstrated decreased sensation to pinprick in the L5 dermatome. The treatment recommendations included a repeat transforaminal epidural steroid injection and continuation of current medication.

IMR ISSUES, DECISIONS AND RATIONALES

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

One transforaminal epidural steroid injections at bilateral L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

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

Decision rationale: The California MTUS Guidelines state epidural steroid injections are recommended as an option for treatment of radicular pain, with use in conjunction with other rehab efforts. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. As per the documentation submitted, the only MRI of the lumbar spine submitted for review is dated 09/07/2011, and only indicated mild posterior bulging at multiple lumbar levels without any canal stenosis or neural foraminal narrowing. Although it is stated that the patient has exhausted previous treatment with physical therapy and chiropractic therapy, documentation of a previous course with a failure to respond was not provided. Additionally, the patient has previously undergone an epidural steroid injection. Documentation of at least 50% pain relief with an associated reduction of medication use for 6 to 8 weeks following the initial injection was not provided. Based on the clinical information received, the request is non-certified.

Norco 10/325mg: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids Page(s): 74-82.

Decision rationale: The California MTUS Guidelines state a therapeutic trial of opioids should not be employed until the patient has failed a trial of non-opioid analgesics. Baseline pain and functional assessment should be made. Ongoing review and documentation of pain relief, functional status, appropriate medication use, and side effects should occur. As per the documentation submitted, the patient has continuously utilized this medication. Despite ongoing use, the patient continues to report persistent pain with activity limitation. There is no change in the patient's physical examination that would indicate functional improvement. Satisfactory response to treatment has not been indicated by a decrease in pain level, increase in function, or improved quality of life. Therefore, continuation cannot be determined as medically appropriate. As such, the request is non-certified.