

Case Number:	CM13-0066885		
Date Assigned:	01/03/2014	Date of Injury:	11/12/1998
Decision Date:	04/21/2014	UR Denial Date:	12/06/2013
Priority:	Standard	Application Received:	12/17/2013

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 Pain 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 patient is a 54-year-old female who reported an injury on 11/12/1998. The mechanism of injury involved a motor vehicle accident. The patient is currently diagnosed with lumbar degenerative disc disease, lumbar radiculitis, and lumbar myofascial pain syndrome. The patient was seen by [REDACTED] on 08/23/2013. The patient reported 8/10 lower back pain. The patient reported improvement in symptoms with the use of a TENS unit, medication, and an exercise program. Physical examination revealed 40 degree flexion of the lumbar spine, 0 degree extension, moderate tenderness to palpation, palpable muscle spasm, dysesthesia in the L5-S1 dermatome, and positive straight leg raising. Treatment recommendations included 2 trigger point injections, a refill of current medications, a request for an L5-S1 epidural steroid injection under fluoroscopic guidance, and continuation of TENS therapy and home exercise.

IMR ISSUES, DECISIONS AND RATIONALES

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

TRIGGER POINT INJECTIONS AT THE LEFT MID TO DISTAL LUMBAR #2 (RETROSPECTIVE): Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 124.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 122.

Decision rationale: The California MTUS Guidelines state that trigger point injections are recommended only for myofascial pain syndrome. The patient has previously been treated with trigger point injections. While the patient does demonstrate palpable muscle spasm with a twitch response upon palpation, there is no documentation of at least 50% pain relief obtained 6 weeks after the initial injection with documented evidence of functional improvement that would warrant the need for a repeat injection. Therefore, the trigger point injections were not medically necessary or appropriate.

AMBIEN 10 MG #30: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chronic Pain Chapter, Insomnia Treatment.

Decision rationale: The Official Disability Guidelines state that insomnia treatment is recommended based on etiology. Ambien is indicated for the short term treatment of insomnia with difficulty of sleep onset for 7 to 10 days. As per the documentation submitted, the patient has continuously utilized this medication. However, there is no documentation of chronic insomnia or sleep disturbance. There is also no evidence of objective improvement as a result of the ongoing use of this medication. There is no documentation of a failure to respond to nonpharmacologic treatment prior to the initiation of a prescription product. Based on the clinical information received, the requested Ambien is not medically necessary or appropriate.

LUMBAR EPIDURAL STEROID INJECTION AT MID L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 66.

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

Decision rationale: The California MTUS Guidelines state that epidural steroid injections are recommended as an option for treatment of radicular pain, with use in conjunction with other rehab efforts. As per the documentation submitted, the patient does demonstrate diminished sensation and diminished strength. However, there is no evidence of a failure to respond to conservative treatment. The patient reports 50% to 60% improvement with the current medication regimen as well as a TENS unit and a home exercise program. There is also no documentation of radiculopathy upon imaging study. Based on the clinical information received, the requested epidural steroid injection is not medically necessary or appropriate.

EPIDUROGRAPHY, RADIOLOGICAL SUPERVISION AND INTERPRETATION:
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.