

Case Number:	CM14-0001874		
Date Assigned:	01/24/2014	Date of Injury:	03/01/2000
Decision Date:	06/23/2014	UR Denial Date:	12/09/2013
Priority:	Standard	Application Received:	01/06/2014

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 & Rehabilitation 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 reported an injury on 03/01/2000 due to a trip and fall which reportedly caused injury to the left side of her body. The injured worker's treatment history included physical therapy, multiple medications, surgical interventions and epidural steroid injections. The injured worker was evaluated on 11/26/2013. It was documented that the injured worker had had good benefit from prior epidural steroid injections. It was noted that the injured worker had 7/10 pain that was reduced to 2/10 to 3/10 pain with medications. Physical findings included tenderness to palpation at the lumbosacral junction with decreased range of motion and a negative straight leg raising test bilaterally. The injured worker's medications included Lidoderm patches, diclofenac sodium, ketamine cream, naproxen sodium, pantoprazole, hydrocodone/APAP, tizanidine, and aspirin. The injured worker's diagnoses included pain in joint lower leg, cervical disc displacement without myelopathy, degenerative lumbar disc disease, sciatica, and tenosynovitis of the ankle and foot. The injured worker's treatment plan included an epidural steroid injection at the L5-S1 and continued medication usage.

IMR ISSUES, DECISIONS AND RATIONALES

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

BILATERAL TRANSFORAMINAL LUMBAR EPIDURAL STEROID INJECTION AT L5-S1 WITH FLUROSCOPIC GUIDANCE AND IV SEDATION: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MTUS Chronic Pain Medical Treatment Guidelines, Epidural Steroid I.

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

Decision rationale: California Medical Treatment Utilization Schedule recommends repeat epidural steroid injections when there is documentation of functional improvement and pain relief of at least 50% for 4 to 6 weeks following the initial procedure. The clinical documentation does indicate that the injured worker has had epidural steroid injections at the L5-S1 previously. It is documented that the injured worker had "good" benefit. However, a quantitative assessment of pain relief regarding the prior injection and documentation of functional benefit for a duration of at least 6 weeks was not provided. Additionally, Official Disability Guidelines do not recommend IV sedation unless there is documentation that the injured worker has a significant fear of needles or the procedure. There is no documentation of excessive anxiety regarding the procedure that would support the need for IV sedation. Therefore, the request for bilateral transforaminal lumbar epidural steroid injection at L5-S1 with fluroscopic guidance and IV sedation is not medically necessary or appropriate.

LUMBAR MYELOGRAPHY AND EPIDUROGRAM: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: ACOEM GUIDELINES, CHAPTER 12- LOW BACK COMPLAINTS, 60

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

Decision rationale: As the requested surgical intervention is not supported by the documentation, the requested ancillary service is also not supported.

LIDODERM PATCHES 5% #30 WITH 3 REFILLS: Upheld

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

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

Decision rationale: California Medical Treatment Utilization Schedule does recommend the use of Lidoderm patches after the injured worker has failed to respond to first line medications. The clinical documentation submitted for review does indicate that the injured worker has been on this medication since at least 01/2013. It is noted within the documentation that the injured worker does have significant pain relief resulting from medication usage and that the injured worker is able to reduce her intake of oral medications as a result of this topical medication. However, the request as it is submitted does not clearly identify a frequency of treatment. In the absence of this information, the appropriateness of the request cannot be determined. Additionally, the request is for 3 refills. This does not allow for timely reassessment and

evaluation of efficacy to support continued use. Therefore, the request for Lidoderm patches 5% #30 with 3 refills is not medically necessary or appropriate.

GABAPENTIN 800MG #90 WITH 3 REFILLS:

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MTUS Chronic Pain Medical Treatment Guidelines, Anti-Epilepsy Drug.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MTUS Chronic Pain Medical Treatment Guidelines, Anti-Epilepsy Drugs Page(s): 16, 60.

Decision rationale: California Medical Treatment Utilization Schedule does support the use of anticonvulsants as a first line medication in the management of chronic pain. The clinical documentation submitted for review does indicate that the injured worker has been taking this medication since at least 01/2013. California Medical Treatment Utilization Schedule recommends that ongoing use of medications in the management of chronic pain be supported by documentation of functional benefit and evidence that the injured worker has significant symptom response to the medication. The clinical documentation submitted for review does indicate that the injured worker has pain relief related to medication usage. However, there is no indication of significant functional benefit related to this medication. Also, the the request as it is submitted does not clearly define a frequency of treatment. In the absence of this information, the appropriateness of the request itself cannot be determined. Also, the request is for 3 refills. This does not allow for timely reassessment and evaluation of efficacy to support continued use. Therefore, the request for Gabapentin 800mg #90 with 3 refills is not medically necessary or appropriate.