MAXIMUS Federal Services

Case Number:	CM14-0105534		
Date Assigned:	07/30/2014	Date of Injury:	08/30/2000
Decision Date:	09/22/2014	UR Denial Date:	06/13/2014
Priority:	Standard	Application Received:	07/08/2014

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 and Rehabilitation and 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 injured worker is a 66 year old female who reported an injury on 08/30/2000. The mechanism of injury was not indicated in the clinical note. Relevant diagnoses included displacement of the thoracic or lumbar intervertebral disc without myelopathy, lumbar poslaminectomy syndrome, lumbosacral spondylosis without myelopathy, and chronic pain syndrome. The past treaments included medications, an epidural steroid injection to the right L5-S1 on 07/05/2013, home exercises, and back surgery. Her diagnostic tests included an MRI on an unspecified date which was noted to show L5-S1 spondylolisthesis with foraminal distortion. Relevant surgical history included a lumbar laminectomy, which was noted to have been approximately 4 years ago. Also noted in the clinical record were 3 unspecified previous back surgeries. Her subjective complaints as of 07/12/2014 were persistent lower lumbar and buttocks pain, rated 6/10. The injured worker stated that the combination of MS Contin 50mg and Norco 10/325 was not as effective on a occasional basis to relieve pain. She had previously rated her pain at 5/10 on 05/01/2014. Physical examination on 07/12/2014 revealed decreased sensation to the right L5 dermatone, deep tendon reflexes +1 at the knees and absent at the ankles, normal motor strength of 5/5 in all muscle groups, and her femoral nerve stretch test was negative. Her medications included MS-Contin, Norco, and Percocet. The treatment plan included continued chronic pain management visits, a repeat right L5 transforaminal steroid injection with fluoroscopic guidance, medication refills, and gentle stretching exercises at home. The rationale for request was not provided. The request for authorization form was signed and submitted on 06/10/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right L5 Transforaminal Steroid Injection Lumbosacral: 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 injections (ESIs) Page(s): 46.

Decision rationale: According to the MTUS Chronic Pain Guidelines the purpose of an epidural steroid injection is to facilitate progress in more active treatment programs. In regard to repeat blocks, the guidelines state that the need for repeat epidural steroid injection should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks. Fluoroscopic guidance should be used for injections. Based on the clinical information provided, the injured worker was noted to have a previous epidural steroid injection on 07/05/2013 which was noted to be "quite effective for several months". However, there was insufficient evidence of quantitative improvement, with at least 50% pain relief for at least 6-8 weeks, and increased function. There was also inadequate documentation showing decreased use of pain medications following previous injection. Therefore, in the absence of clear documentation showing significant improvement following her previous injection with the parameters outlined by the guidelines, the request is not supported. As such, the request is not medically necessary and appropriate.

Fluoroscopic Guidance for Spine Injection:

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.