

Case Number:	CM14-0151701		
Date Assigned:	09/19/2014	Date of Injury:	10/02/2010
Decision Date:	10/21/2014	UR Denial Date:	09/10/2014
Priority:	Standard	Application Received:	09/17/2014

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, has a subspecialty in Interventional Spine and is licensed to practice in California. 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 with an injury date of 10/02/10. Per the 08/28/14 report by [REDACTED], the patient presents with chronic lower back pain radiating into her left lower extremity down to her foot with associated numbness and tingling. She also states she has poor concentration, memory and weakness as well and anxiety and depression. Examination reports the patient has antalgic gait but ambulates without assistance. The patient's diagnosis is lumbar disc displacement without myelopathy. Current medication is listed as Tramadol, Gabapentin, Norflex and Venlafaxine. The utilization review being challenged is dated 09/06/14. Reports were provided from 01/15/12 to 09/17/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 left transforaminal LESI at L5-S1 to include: lumbar epidurogram, contrast dye, IV sedation, and fluoroscopic guidance: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines ESI's Page(s): 46-47.

Decision rationale: The patient presents with lower back pain radiating to the "left lower extremity to the foot" with numbness and tingling. The physician requests for 1 left transforaminal LESI at L5-S1 to include lumbar epidurogram, contrast dye, IV sedating and fluoroscopic guidance. On 09/05/14 the physician notes that the patient has sensory deficit at L5-S1 dermatomal distribution and she may be amenable to an epidural injection depending on the results of her MRI. On 08/28/14 [REDACTED] notes he patient is also noted to have had an Epidural Steroid Injection in the past, however, with caudal approach. The results of the ESI were not discussed. The report also cites an MRI from 2011 that shows a large disc fragment posteriorly centered into the left at L5-S1 causing "left" foraminal stenosis. A copy of this report was not provided. In this case, the patient presents with pain radiating into the lower extremity, examination reveals sensory deficit at the L5-S1 dermatomal distribution and the MRI cited from 2011 reports left foraminal stenosis at L5-S1. The patient already tried an ESI in the past and the physician does not discuss the results. MTUS requires 50% reduction of pain for 6 weeks or more, functional improvement with reduction of medication use. Given the lack of documentation of improvement from the prior ESI, a repeat ESI would not be indicated. MTUS does not different effectiveness of different ESI approaches. Therefore the request is not medically necessary.

1 request for an initial evaluation for a Functional Restoration Program: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Chronic pain programs (functional restoration programs) Page(s): 30-33.

Decision rationale: The patient presents with lower back pain radiating to the "left lower extremity to the foot" with numbness and tingling. The physician requests for Initial evaluation for a Functional restoration program. The MTUS guidelines on pages 30-32 state that functional restoration programs for chronic pain are recommended when there is access to programs with proven successful outcomes. The first criteria of the general use of these programs is, "1) An adequate and thorough evaluation has been made, including baseline functional testing so follow-up with the same test can note functional improvement;" The 08/27/14 report by [REDACTED] states, "this patient has been having persistent and worsening low back pain and radicular pain since 2010." The physician further states the patient has great difficulty with ADL's including standing at the sink, stove or showers, she does not get dressed and washes with difficulty and can walk only limited distances with an aid. Her pain is severe most of the time. The patient's symptoms and medication (Venlafaxine) for depression are noted. In this case, there seems sufficient evidence that this patient has conditions that place her at risk for delayed recovery. There is no reason the patient should not be afforded an evaluation to determine her suitability for a Functional restoration program that may afford her the opportunity to learn skills to cope with her chronic condition. Therefore the request is medically necessary.