MAXIMUS Federal Services

Case Number:	CM14-0176857		
Date Assigned:	10/30/2014	Date of Injury:	08/16/2013
Decision Date:	12/05/2014	UR Denial Date:	09/29/2014
Priority:	Standard	Application Received:	10/24/2014

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 Family Medicine and is licensed to practice in New Jersey. 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 worker is a 44 year old female who was injured on 8/16/13 after slipping on a wet floor. She was diagnosed with lumbago, lumbar strain, multilevel facet arthritis, and Scheuermanns disease. She was treated with physical therapy and multiple medications including opioids, NSAIDs, muscle relaxants, anti-epileptics, benzodiazepines, and Toradol injections. MRI of the lumbar spine from 7/10/14 showed mild chronic multilevel disc degeneration with no impingement of any nerves. On 8/26/14, the worker was seen by her primary treating physician complaining of right hip pain with radiation down her right leg and continual low back pain. She reported using Oxycontin and Norco which helped the pain. She also reported taking Motrin, Flexeril, Clonazepam, Gabapentin, Loratadine, Albuterol, and Carvedilol. Physical examination documentation stated "signs and symptoms are the same". Looking back to a previous progress note (8/11/2014) findings included lumbar paraspinal spasm and tenderness, positive straight leg raise, normal motor strength and sensory examination except for a diminished ankle jerk on right, antalgic gait, and good heel/toe walking ability. She was then recommended to see pain management as well as see an anesthesiologist for epidural consideration. She was also recommended to reduce her Oxycontin. She was given a Toradol injection that same day as well.

IMR ISSUES, DECISIONS AND RATIONALES

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

Consult only with anesthesiologist for epidural injection: 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 Page(s): 46.

Decision rationale: The MTUS Guidelines state that epidural steroid injections are recommended as an option for treatment of lumbar radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) and can offer short term pain relief, but use should be in conjunction with other rehab efforts, including continuing a home exercise program. The criteria as stated in the MTUS Guidelines for epidural steroid injection use for chronic pain includes the following: 1. radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnositic testing, 2. Initially unresponsive to conservative treatment (exercise, physical methods, NSAIDs, and muscle relaxants), 3. Injections should be performed using fluoroscopy for guidance, 4. If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections, 5. no more than two nerve root levels should be injected using transforaminal blocks, 6. no more than one interlaminar level should be injected at one session, 7. in the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pan relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year, and 8. Current research does not support a "series-of-three" injections in either the diagnostic or therapeutic phase, and instead only up to 2 injections are recommended. In the case of this worker, there was not enough objective evidence from MRI or physical examination findings that would clearly diagnose radiculopathy from a lumbar root nerve. Referral for a procedure (epidural injection) based on this inconclusive diagnosis seems unnecessary. Therefore, the referral for epidural injection is not medically necessary.

Consult only with pain management: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation American College of Occupational and Environmental Medicine (ACOEM), 2nd Edition, (2004) page 127and on the Official Disability Guidelines (ODG): Opioids page 124, 77, 81.

Decision rationale: The MTUS/ACOEM Guidelines state that referral to a specialist(s) may be warranted if a diagnosis is uncertain, or extremely complex, when psychosocial factors are present, or when the plan or course of care may benefit from additional expertise in assessing therapeutic management, determination of medical stability, and permanent residual loss and/or examinee's fitness for return to work, and suggests that an independent assessment from a consultant may be useful in analyzing causation or when prognosis, degree of impairment, or work capacity requires clarification. Specifically with those taking opioids, a pain specialist may

be helpful and warranted in cases where subjective complaints do not correlate with imaging studies and/or physical findings and/or when psychosocial issue concerns exist, when dosing of opioids begins to approach the maximum recommended amounts, or when weaning off of opioids proves to be challenging. In the case of this worker, she was already being weaned down on her opioid therapy without any documented report of problems associated with this. Also, there was no evidence that the primary provider needed any specific help with managing this patient in regards to her getting a procedure, managing medication, or help with diagnosing. Therefore, the referral to a pain specialist is not medically necessary and appropriate.