

Case Number:	CM14-0062678		
Date Assigned:	07/11/2014	Date of Injury:	06/08/2005
Decision Date:	09/17/2014	UR Denial Date:	04/24/2014
Priority:	Standard	Application Received:	05/05/2014

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 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 injured worker is a 49-year-old female who reported an injury on 06/06/2005. The mechanism of injury was not provided. On 06/20/2014, the injured worker presented with low back pain with radiation into the bilateral posterior lower extremities to the feet. Prior surgeries included a hysterectomy in 2004 and right total hip arthroplasty in 2007. Diagnostic studies included an MRI of the lumbar spine performed on 07/25/2013, which revealed disc desiccation present at the L3-4 and L4-5 and L5-S1. There was also a mild broad-based disc protrusion at the L3-4 and central canal dimensions and neural foramina patent. The diagnoses were degenerative of the lumbosacral disc, disorders of the sacrum, sciatica, and spondylosis of the lumbosacral. The injured worker had a prior lumbar Epidural Steroid Injection on 05/20/2014 which gave her good relief. Upon examination, there were reports of balance problems, poor concentration, memory loss, numbness, weakness, and anxiety and depression. Prior therapy included medications and an epidural steroid injection. The provider recommended an epidural steroid injection and an Epidurogram of Robaxin. The provider's rationale was not provided. The Request for Authorization form was not included in the medical documents for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left Transforaminal lumbar Epidural Steroid Injection L5-S1 One month apart x 3.:
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 Epidural Steroid Injections Page(s): 46.

Decision rationale: The request for a left Transforaminal Lumbar Epidural Steroid Injection at L5-S1 (1 month apart) times 3 is not medically necessary. According to the California MTUS Guidelines, an Epidural Steroid Injection may be recommended to facilitate progress in more active treatment programs when there is radiculopathy documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Additionally, documentation should show that the injured worker was initially unresponsive to conservative treatment. Injections should be performed using fluoroscopy for guidance and no more than 2 root levels should be injected using transforaminal blocks. Repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for 6 to 8 weeks, with a general recommendation of no more than 4 blocks per region per year. The documentation submitted for review lacked evidence of physical examination findings of radiculopathy corroborated by imaging studies. Further clarification is needed to address motor strength deficits, sensory deficits, results of a straight leg raise, and evidence that the injured worker would be participating in an active treatment program following the requested injection. There was lack of documentation of the efficacy of the prior epidural steroid injection, to include 50% pain relief with associated reduction of medication for up to 6 to 8 weeks. The provider's request for an epidural steroid injection for L5-S1 exceeds the guideline recommendations of no more than 2 root levels. The guidelines do not support intravenous sedation with the use of an epidural steroid injection. Based on the above, the request is not medically necessary.

One Lumbar Epidurogram x 3: Upheld

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

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 service are medically necessary.

Contrast Dye: Upheld

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

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.

Intravenous Sedation: Upheld

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

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.

Fluoroscopic Guidance.: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of Epidural steroid injections.

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.

Robaxin 750mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle Relaxants Page(s): 63.

Decision rationale: The request for Robaxin 750 mg with a quantity of 90 is not medically necessary. The California MTUS Guidelines recommend non-sedating muscle relaxants with caution as a second line option for the short-term treatment of acute exacerbation. They show no benefit beyond NSAIDs in pain and overall improvement and efficacy appears to diminish over time. Following the use of some medications in this class may lead to dependence. The provider's request for Robaxin 750 mg with a quantity of 90 exceeds the guideline recommendation of short-term treatment. Additionally, the efficacy of the prior use of the medication has not been provided. The provider's request does not indicate the frequency of the medication in the request as submitted. As such, the request is not medically necessary.