

Case Number:	CM14-0063502		
Date Assigned:	07/11/2014	Date of Injury:	06/04/2004
Decision Date:	08/12/2014	UR Denial Date:	04/03/2014
Priority:	Standard	Application Received:	05/06/2014

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 Anesthesiology, has a subspecialty in Pain Management 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:

According to the records made available for review, this is a 53-year-old male with a 6/4/04 date of injury. At the time (4/3/14) of request for authorization for Right S1 transforaminal epidural steroid injection and Gabapentin 600 mg #90, there is documentation of subjective (neck and low back pain that radiates to the right lower extremity, pain 8-9/10 without medications and 4/10 with medications) and objective (patella reflexes 2+, absent left Achilles reflex, trace right Achilles reflex, strength decreased in both lower extremities more so on right, positive straight leg raise on right causing pain down posterior leg) findings, current diagnoses (Low Back Pain), and treatment to date (medications (including ongoing treatment with Gabapentin with 30% reduction in leg pain and increased activity tolerance) and prior S1 lumbar epidural steroid injection (with 50% pain relief for 5-6 months)). Regarding Right S1 transforaminal epidural steroid injection, there is no documentation of decreased need for pain medications, and functional response following previous epidural steroid injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right S1 transforaminal epidural steroid injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines epidural steroid injections Page(s): 46.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Epidural Steroid Injections (ESIs).

Decision rationale: MTUS reference to ACOEM guidelines identifies documentations of objective radiculopathy in an effort to avoid surgery as criteria necessary to support the medical necessity of epidural steroid injections. ODG identifies documentation of at least 50-70% pain relief for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year, as well as decreased need for pain medications, and functional response as criteria necessary to support the medical necessity of additional epidural steroid injections. Within the medical information available for review, there is documentation of a diagnosis of low back pain. In addition, given documentation of 50% pain relief for 5-6 months with prior S1 lumbar epidural steroid injection, there is documentation of at least 50-70% pain relief for six to eight weeks. However, there is no documentation of decreased need for pain medications and functional response following previous epidural steroid injection. Therefore, based on guidelines and a review of the evidence, the request for Right S1 transforaminal epidural steroid injection is not medically necessary.

Gabapentin 600 mg #90: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines chronic pain Page(s): 18.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Gabapentin (Neurontin) Page(s): 18-19.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines identifies documentation of neuropathic pain, as criteria necessary to support the medical necessity of Neurontin (gabapentin). MTUS-Definitions identifies that any treatment intervention should not be continued in the absence of functional benefit or improvement as a reduction in work restrictions; an increase in activity tolerance; and/or a reduction in the use of medications or medical services. Within the medical information available for review, there is documentation of a diagnosis of low back pain. In addition, there is documentation of neuropathic pain. Furthermore, given documentation of ongoing treatment with Gabapentin, there is documentation of functional benefit and improvement as an increase in activity tolerance as a result of Gabapentin use to date. Therefore, based on guidelines and a review of the evidence, the request for Gabapentin 600 mg #90 is medically necessary.