

Case Number:	CM14-0070699		
Date Assigned:	07/14/2014	Date of Injury:	10/12/2011
Decision Date:	09/17/2014	UR Denial Date:	05/09/2014
Priority:	Standard	Application Received:	05/16/2014

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, 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:

This is a patient with a date of injury of 10/12/11. A utilization review determination dated 5/9/14 recommends non-certification of transforaminal lumbar ESI and initial evaluation for FRP. It noted that prior ESI gave 70% symptom reduction for 4-5 weeks with no reduction in medication use. 6/26/14 medical report identifies pain in the chest, neck, right shoulder, right leg, back, and right side of the ribs. On exam, there is 4/5 strength in all tested muscles of the right upper extremity. Spasm and guarding is noted in the lumbar spine. The provider noted that the prior lumbar ESI gave 5 weeks of pain reduction before the pain returned. He had 70% improvement in function and was able to walk better. The provider also noted that the initial evaluation in the FRP was denied.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Right L4-L5 and L5-S1 Transforaminal lumbar Epidural Steroid Injection, with Lumbar Epidurogram , IV sedation, Fluoroscopic Guidance, Contrast Dye: 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 Chronic Pain Guidelines state that epidural injections are recommended as an option for the treatment of radicular pain, defined as pain in dermatomal distribution with corroborative findings of radiculopathy. Regarding repeat epidural injections, guidelines state that 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 six to eight weeks, with a general recommendation of no more than 4 blocks per region per year. Within the documentation available for review, the patient is noted to have received relief from prior injection, but the duration was less than the six weeks recommended by the MTUS Chronic Pain Guidelines prior to consideration for repeating the procedure. Furthermore, there was no reduction in pain medication usage noted. Finally, there are no clear radicular symptoms/findings noted on the current exam to support repeating an epidural steroid injection. In the absence of such documentation, the currently requested transforaminal lumbar epidural steroid injection is not medically necessary.

1 Initial Evaluation for Multidisciplinary functional Restoration Program: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 30-34 and 49 of 127.

Decision rationale: The MTUS Chronic Pain Guidelines supports chronic pain programs/functional restoration programs when: Previous methods of treating chronic pain have been unsuccessful and there is an absence of other options likely to result in significant clinical improvement; The patient has a significant loss of ability to function independently resulting from the chronic pain; The patient is not a candidate where surgery or other treatments would clearly be warranted; The patient exhibits motivation to change, and is willing to forgo secondary gains, including disability payments to effect this change; & Negative predictors of success have been addressed. Within the medical information available for review, there is no statement indicating that other methods for treating the patient's pain have been unsuccessful and that there are no other treatment options available (and it should be noted that the provider is also pursuing other treatment options including interventional treatment). There is no statement indicating that the patient has lost the ability to function independently and no discussion regarding motivation to change and negative predictors of success. In the absence of clarity regarding the above issues, the currently requested initial evaluation for multidisciplinary functional restoration program is not medically necessary.