

Case Number:	CM14-0202874		
Date Assigned:	12/15/2014	Date of Injury:	01/10/2008
Decision Date:	01/31/2015	UR Denial Date:	11/21/2014
Priority:	Standard	Application Received:	12/04/2014

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 Emergency Medicine 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:

Patient with reported date of injury on 1/10/2008. No mechanism of injury was documented. Diagnosis listed are lumbar strain, lumbar disc disease with radiculopathy, lumbar facet syndrome, sacroiliac discopathy and sleep problems. Medical reports reviewed. Last report available until 11/6/14. Patient complains of low back pain and hip pain. Pain is 4/10. Pain has "increased". Objective exam reveals tenderness of paraspinals of lumbar and L3-S1 facets. Positive for Fabere's/Patrick sign, sacroiliac thrust, Yeoman's, Kemp's and straight leg raise. Antalgic gait. Decreased sensation along Left L4, bilateral L5 and L S1 dermatomes. There is no justification for epidural requested documented on request. MRI of lumbar spine(10/7/14) revealed multilevel central and neural foraminal stenosis with multiple level disc dessication. Current medications include Norco, Ultram and Ambien. Patient had reportedly prior ESI done on 12/12. Pain improved by 30-40%. Independent Medical Review is for transforaminal epicureal steroid injection at L4-5 and L5-S1; and Ambien 10mg #30. Prior Utilization Review on 11/21/14 recommended non-certification.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 transforaminal epidural steroid injection at L4-L5 and L5-S1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections(ESI) Page(s): 46.

Decision rationale: As per MTUS Chronic Pain Guidelines, Epidural Steroid Injections (ESI) may be useful in radicular pain and may be recommended if it meets criteria. 1) Goal of ESI: ESI has no long term benefit. It can decrease pain in short term to allow for increasingly active therapy or to avoid surgery. The documentation fails to provide rationale for LESI. Pain has been stable but "worst" due to denial of medications. There is no long term plan. Fails criteria.2) Unresponsive to conservative treatment. There is no appropriate documentation of prior conservative therapy attempts. There are no medications currently prescribed for neuropathic pain listed.3) Patient had a reported LESI in the past. MTUS guidelines recommend during therapeutic phase that after 1st injection, pain relief of over 50% should last for up to 6-8weeks. There is no documentation of appropriate improvement with prior reported LESI. Patient fails multiple criteria for lumbar epidural steroid injection and therefore, lumbar epidural steroid injection is not medically necessary.

Ambien 10mg #30: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Pain (Chronic)

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) <Pain(Chronic)>, <Insomnia Treatment>

Decision rationale: There are no specific sections in the MTUS chronic pain or ACOEM guidelines that relate to this topic. Ambien is a benzodiazepine agonist approved for insomnia. As per ODG guidelines, it recommends treatment of underlying cause of sleep disturbance and recommend short course of treatment. Long term use may lead to dependency. Patient has been on Ambien chronically. There is no documentation of other conservative attempts at treatment of sleep disturbance or sleep studies. The prescription is excessive and not consistent with short term use or attempts to wean patient off medication. The chronic use of Ambien is not medically appropriate and is not medically necessary.