

Case Number:	CM14-0102088		
Date Assigned:	07/30/2014	Date of Injury:	11/10/2001
Decision Date:	06/23/2015	UR Denial Date:	06/26/2014
Priority:	Standard	Application Received:	07/02/2014

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: California

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 51 year old male, who sustained an industrial injury on November 10, 2001. The injured worker's initial complaints and diagnoses are not included in the provided documentation. The injured worker was diagnosed as having postlaminectomy syndrome of lumbar region, lumbar intervertebral disc displacement, disorders of sacrum, chronic pain syndrome, thoracic or lumbosacral neuritis or radiculitis - unspecified, lumbar facet joint pain, lumbar radiculopathy, osteoarthritis of spinal facet joint, and traumatic arthropathy of sacroiliac joint. Diagnostic studies to date have included a CT and an MRI. Treatment to date has included a left sacroiliac joint steroid injection, physical therapy, ice, chiropractic therapy, a home exercise program, and medications including short-acting and long acting opioid pain, anti-epilepsy, muscle relaxant, and non-steroidal anti-inflammatory. On January 16, 2015, the injured worker complains of constant, dull low back pain with intermittent tingling pain in the lateral legs from hips to heels. His pain is rated 7-8/10 without medications and 6/10 with medications. The physical exam of the lumbar spine revealed normal midline scars, lumbosacral tenderness, significant spasms of the paraspinal muscles, positive straight leg raise, restricted range of motion, hypoesthesia of the posterior legs, and decreased deep tendon reflexes of both legs. The requested treatments include a left lumbar 5-sacral 1 transforaminal epidural steroid injection and Naproxen. The lumbar CT scan dated August 25, 2010 identifies no identification of neuroforaminal stenosis.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Left Transforaminal ESI L5-S1 epidural steroid injection: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.20-9792.26 Page(s): 46 of 127.

Decision rationale: Regarding the request for Lumbar epidural steroid injection, Chronic Pain Medical Treatment Guidelines state that epidural injections are recommended as an option for treatment of radicular pain, defined as pain in dermatomal distribution with corroborative findings of radiculopathy, and failure of conservative treatment. Guidelines recommend that no more than one interlaminar level, or to transforaminal levels, should be injected at one session. 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, there are no recent subjective complaints or objective examination findings supporting a diagnosis of radiculopathy in a specific dermatomal distribution. Additionally, there are no imaging or electrodiagnostic studies corroborating the diagnosis of radiculopathy at the proposed treatment level. In the absence of such documentation, the currently requested Lumbar epidural steroid injection is not medically necessary.

Unknown prescription of Naproxen with 3 refills: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 8 C.C.R. 9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page(s): 67-72 of 127.

Decision rationale: Regarding the request for Naproxen, Chronic Pain Medical Treatment Guidelines state that NSAIDs are recommended at the lowest dose for the shortest period in patients with moderate to severe pain. Within the documentation available for review, there is no indication that Naproxen is providing any specific analgesic benefits (in terms of percent pain reduction, or reduction in numeric rating scale), or any objective functional improvement. Additionally, the current request does not include a quantity of pills, frequency of use, or duration of use. Guidelines do not support the open-ended application of any medication. As such, the currently requested Naproxen is not medically necessary.