

Case Number:	CM14-0219248		
Date Assigned:	01/09/2015	Date of Injury:	10/26/2014
Decision Date:	03/10/2015	UR Denial Date:	12/26/2014
Priority:	Standard	Application Received:	12/31/2014

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, Indiana, New York
Certification(s)/Specialty: Internal Medicine

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 39 year old male, who sustained an industrial injury on 10/26/14. He has reported low back pain. The diagnoses have included lumbago. Treatment to date has included medications. (MRI) magnetic resonance imaging of lumbar spine was previously completed. Currently, the IW complains of back and leg pain. On physical exam there is no midline lumbosacral spine tenderness, no paraspinal muscle tenderness and seated straight leg raise is negative for pain. Current include oral medications. On 12/26/14 Utilization Review non-certified an epidural injection noting the purpose of the injection is to reduce pain and inflammation, there is not sufficient documentation of pain on the physical exam and certified Skelaxin. The MTUS, ACOEM Guidelines, (or ODG) was cited. On 12/26/14, the injured worker submitted an application for IMR for review of epidural injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

INJECTION-EPIDURAL INJECTION 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 injection Page(s): 46. Decision based on Non-MTUS Citation Pain section, Epidural steroid injection

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, epidural steroid injection L5 - S1 is not medically necessary. Epidural steroid injections are recommended as an option for treatment of radicular pain. The criteria for use of epidural steroid injections are enumerated in the Official Disability Guidelines. They include, but are not limited to, radiculopathy must be documented by physical examination and corroborated by imaging studies and or electrodiagnostic testing; initially unresponsive to conservative treatment; etc. In this case, the injured worker's working diagnosis is low back pain with radiation, right. Subjectively, the injured worker complains of low back pain with right radicular symptoms. Objectively, there is no midline lumbosacral spine tenderness and no paraspinal muscle tenderness. The documentation contains subjective evidence of right radicular symptoms. However, there is no objective documentation of radiculopathy. Epidural steroid injection criteria include radiculopathy documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. There were no electrodiagnostic studies in the medical record and an MRI of the lumbosacral spine was pending. Moreover, the physical examination was essentially normal. Consequently, absent clinical documentation to support radiculopathy with imaging studies and electrodiagnostic studies, epidural steroid injection L5 - S1 is not medically necessary.

SKELAXIN 800MG #90: Overturned

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Muscle relaxants Page(s): 63-66. Decision based on Non-MTUS Citation Pain section, Muscle relaxants

Decision rationale: Pursuant to the Chronic Pain Medical Treatment Guidelines and the Official Disability Guidelines, Skelaxin 800 mg #90 is medically necessary. Muscle relaxants are a second line option for short-term (less than two weeks) treatment of acute low back pain and for short-term treatment of acute exacerbations in patients with chronic low back pain. Efficacy appears to diminish over time and prolonged use may lead to dependence. The documentation on page 13 of the medical record indicates Skelaxin 800 mg #90 was certified by the initial reviewing physician.