

Case Number:	CM14-0071897		
Date Assigned:	07/16/2014	Date of Injury:	05/15/2002
Decision Date:	06/04/2015	UR Denial Date:	05/02/2014
Priority:	Standard	Application Received:	05/19/2014

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: New York

Certification(s)/Specialty: Emergency 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 (IW) is a 43-year-old female with an industrial injury dated 05/15/2002. Her diagnoses include left lumbar 5 radiculopathy, lumbar disc protrusions at lumbar 3-4, lumbar 4-5 and central at lumbar 5-sacral 1, lumbar facet syndrome, lumbar degenerative disc disease at lumbar 3-4, lumbar 4-5 and lumbar 5- sacral 1 and cervical disc degeneration. Prior documented treatment was medications and home exercises. She presents on 02/11/2014 with complaints of neck pain and low back pain radiating into the left leg. Objective findings included tenderness over the lumbar spine area. She experienced pain with extension and with right and left lateral movement. The provider documented the injured worker had to stop anti-inflammatory medications due to gastrointestinal upset and had an endoscopy. Treatment plan included pain management referral for an epidural steroid injection, muscle relaxant and stomach protectant medication. On 04/28/2014, the physician notes the request for pain management consultation and epidural steroid injection is being resubmitted. On 5/1/2015 Utilization Review non-certified requests for a pain management consultation, epidural steroid injection, and prescription for Flexeril and Prilosec. CA MTUS chronic pain and ACOEM guidelines were referenced in support of these decisions.

IMR ISSUES, DECISIONS AND RATIONALES

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

Transforaminal Epidural Steroid Injection form the left at L5-S1 with a Facet Block at L4-L5 and L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309, Postsurgical Treatment Guidelines.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection.

Decision rationale: CA MTUS recommends epidural injections when a patient has symptoms, physical examination findings, and radiographic or electrodiagnostic evidence to support a radiculopathy. In this case, the radiographic findings do not document findings supportive of radiculopathy such as nerve root impingement. There are no electrodiagnostic studies included in the chart material. The IW reports radiculopathy, but physical examination does not document any radiculopathy. Without these items, the request for an epidural steroid injection is not medically necessary.

Pain Management Consultation: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Chronic Pain Disorder Treatment Guidelines, State of Colorado Department of Labor and Employment, 4/27/2007, page 56.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

Decision rationale: The request for a pain management consultation is stated to be for the epidural steroid injection. As the injection is not medically necessary, the referral request is also not medically necessary.

Flexeril 10mg #90: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Cyclobenzaprine Page(s): 41-42.

Decision rationale: According to CA MTUS, cyclobenzaprine is recommended as an option for short course of therapy. Effect is noted to be modest and is greatest in the first 4 days of treatment. The IW has been receiving this prescription for a minimum of 6 months according to submitted records. This greatly exceeds the recommended timeframe of treatment. In addition, the request does not include dosing frequency or duration. The IW's response to this medication is not discussed in the documentation. The request is not medically necessary.

Prilosec 20mg #30: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI Symptoms & Cardiovascular risk.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines NSAIDS, GI symptoms & cardiovascular risk Page(s): 68-69.

Decision rationale: According to CA MTUS, gastrointestinal protectant agents are recommended for patients that are at increased risk for gastrointestinal events. These risks include age >65, history or gastrointestinal bleeding or peptic ulcers, concomitant use of NSAIDs and corticosteroids or aspirin, or high dose NSAID use. The chart documents indicate the IW was previously taking NSAIDS, but stopped use because of stomach irritation. The IW is not currently taking NSAIDS. Without the use of this medication, Prilosec is not medically necessary based on the MTUS.