

Case Number:	CM15-0073884		
Date Assigned:	04/24/2015	Date of Injury:	01/19/2013
Decision Date:	05/22/2015	UR Denial Date:	03/27/2015
Priority:	Standard	Application Received:	04/20/2015

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: Preventive Medicine, Occupational 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 53 year old female who sustained an industrial injury on 3/27/15. The mechanism of injury is unclear. She currently complains of left elbow and wrist pain and intermittent right hip pain. Her numbness in the left hand and thumb has improved. She has right hand and thumb pain. Her low back pain has increased but not as constant. Lumbar MRI (12/1/14) showed degenerative disc disease at L1-2 and L4-5, and moderately severe facet arthritis at L4-5. Medications are baclofen, Dilaudid, gabapentin, Metamucil, Senna, Percocet, orphenadrine, docusate sodium and oxycodone. Diagnoses include status post left cubital tunnel release and carpal tunnel release (3/3/15); status post right hip replacement (1999); total hip replacement revision (2002); ulnar nerve neuropathy left elbow; carpal tunnel syndrome left wrist; degenerative disc disease. Diagnostics include MR of the lumbar spine (12/1/14) showing degenerative disc disease at L1-2 and L4-5 and moderately severe facet arthritis at L4-5. In the progress note dated 3/17/15 the treating provider's plan of care requests epidural steroid injection and facet injection at the lumbar spine as the injured worker cannot perform household chores; in addition per Utilization Review there was a request for pain management specialist for the lumbar spine.

IMR ISSUES, DECISIONS AND RATIONALES

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

Pain Management consult for the lumbar spine: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 5 Cornerstones of Disability Prevention and Management, Chapter 2 General Approach to Initial Assessment and Documentation Page(s): Chp 2 pg 21, Chp 5 pg 79, 89-90, 92.

Decision rationale: Decision on when to refer to a specialist is based on the ability of the provider to manage the patient's disease. It relates to the provider's comfort point with the medical situation and the provider's training to deal with that situation. In this case, the provider has a patient with chronic lumbar pain, not improved with medical intervention. His referral to a pain specialist to manage the patient's chronic pain is appropriate if he does not feel comfortable doing the management. This is implied when a provider requests a referral. Medical necessity has been established and the request is medically necessary.

Lumbar epidural steroid injection at L4-L5: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 288, 309-10, Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs), Chronic Regional Pain Syndrome (sympathetic and epidural blocks) Page(s): 39-40, 46.

Decision rationale: The best medical evidence today for individuals with low back pain indicates that having the patient return to normal activities provides the best outcomes. Therapy should be guided, therefore, with modalities, which will allow this outcome. Epidural steroid injections are an optional treatment for pain caused by nerve root inflammation as defined by pain in a specific dermatome pattern consistent with physical findings attributed to the same nerve root. As per the MTUS the present recommendations is for no more than 2 such injections, the second being done only if there is at least a partial response from the first injection. Its effects usually will offer the patient short term relief of symptoms as they do not usually provide relief past 3 months, so other treatment modalities are required to rehabilitate the patient's functional capacity. The MTUS provides very specific criteria for use of this therapy. Specifically, the presence of a radiculopathy documented by examination and corroborated by imaging, and evidence that the patient is unresponsive to conservative treatment. In the documented care for this patient these criteria are not met. Even though the history is compatible with a possible radiculopathy, this is not supported by the exam, which is non-specific for a radiculopathy. Additionally, the degenerative changes in the lumbar spine noted on the lumbar MRI are non-specific and do not describe nerve impingement. Thus, the patient does not meet the criteria for this requested therapy and is not medically necessary.

Facet injection at L4-L5: Overturned

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-1, 309. Decision based on Non-MTUS Citation American Society of Interventional Pain Physicians: Comprehensive evidence-based guidelines for interventional techniques in chronic spinal pain. Part II: guidance and recommendations Source: <http://www.guideline.gov/content.aspx?id=45379#Section420>.

Decision rationale: Lumbar facet injections are an option in the treatment of pain caused by facet inflammation. The ACOEM guidelines point out its use is primarily of diagnostic benefit as there is inadequate evidence-based support for its use therapeutically. The American Society of Interventional Pain Physicians also notes good evidence to support its use as a diagnostic modality but note only fair evidence to support its therapeutic use. However, it only recommends the therapeutic use of facet injections for use after the appropriate diagnosis with controlled diagnostic lumbar facet joint blocks. The request for this procedure does not specifically differentiate whether it is for diagnostic or therapeutic benefit. Medical necessity for the therapeutic use of this procedure is not met but it would be appropriate for diagnostic purpose. As the patient has not had a prior L4-5 facet block medical necessity for this procedure has been established and the request is medically necessary.