

Case Number:	CM13-0005478		
Date Assigned:	08/19/2013	Date of Injury:	12/14/2000
Decision Date:	01/10/2014	UR Denial Date:	07/15/2013
Priority:	Standard	Application Received:	08/01/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation 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 physician 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:

The underlying date of injury in this case is 12/14/2000. The primary diagnosis is cervicalgia. Treating diagnoses include lumbar radiculopathy, lumbar facet arthropathy, cervical radiculopathy, cervical facet arthropathy, status post cervical fusion x2, and chronic pain. A lumbar MRI of 07/16/2012 demonstrated multilevel degenerative disc disease at L2-S1 with bulges unchanged since a prior study from 2010. Progressive encroachment, however, was noted in the right lateral foramen at L4-L5 with likely impingement on the exiting L4 nerve on the right. A prior physician review discusses a physician followup visit of 06/24/2013 when the patient complained of back pain into the right lower extremity with associated numbness and tingling and also complaints of neck pain. That physician review notes that the provider described a positive response to recent lumbar epidural injection. The prior physician reviewer noted that there was no objective documentation of pain relief and functional improvement and that the patient did not meet the criteria for a repeat therapeutic injection. On review of the treating record from 06/24/2013 the treating physician notes that the patient had recently undergone a therapeutic lumbar epidural injection and was seen in reevaluation. The patient reported a positive response, and therefore the physician requested an additional therapeutic injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

One additional therapeutic transforaminal epidural steroid injection using fluoroscopy at the right L4-L5 level: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Opioids, criteria for use.

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

Decision rationale: The treating notes in this case specifically indicate that the requested repeat injection is a therapeutic rather than diagnostic injection. The MTUS Chronic Pain Guidelines Section on Epidural Injections, page 46, states, "In the therapeutic phase, 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 6-8 weeks." The medical records in this case do not meet these criteria for a repeat therapeutic epidural injection, and the medical records do not provide an alternate rationale for this request. The request for one additional therapeutic transforaminal epidural steroid injection using fluoroscopy at the right L4-L5 level is not medically necessary and appropriate.