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| Case Number: | CM13-0018691 | | |
| Date Assigned: | 06/06/2014 | Date of Injury: | 03/24/2004 |
| Decision Date: | 07/11/2014 | UR Denial Date: | 08/12/2013 |
| Priority: | Standard | Application Received: | 08/30/2013 |

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in New York and Texas. 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/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 injured worker is a 47 year old female whose date of injury is 03/24/2004. The mechanism of injury is not described. Note dated 01/20/14 indicates that the injured worker is status post left L4-5 decompression. MRI of the lumbar spine dated 02/19/14 revealed no evidence for disc herniation, spinal canal stenosis or neural foraminal narrowing at T12-L1, L1-2, and L2-3. At L3-4 there is a 3 mm disc bulge eccentric to the left with posterior annular fissure and partial disc desiccation contributing to mild bilateral foraminal narrowing. The spinal canal is patent. At L4-5 there is a 5 mm disc bulge/osteophyte complex eccentric to the left contributing to mild right and moderate left foraminal narrowing and to mild left sided subarticular zone stenosis. At L5-S1 there is a 4 mm generalized disc bulge/osteophyte complex with partial disc desiccation and annular fissuring; mild left sided foraminal narrowing is present. Follow up note dated 05/15/14 indicates that the injured worker has been made permanent and stationary. Permanent and stationary report dated 05/17/14 indicates that on physical examination the injured worker is able to forward flex to 45 degrees, extend to 15 degrees, left lateral bend to 10 degrees and right lateral bend to 15 degrees. She does not have any motor deficits. Sensation is diminished to light touch along the left L5 dermatome. Impression is lumbago; status post decompression L4-5 left sided x 2, segmental instability L4-5, persistent L5 radiculopathy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left lumbar transforminal epidural steroid injection: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections Page(s): 46.

Decision rationale: Based on the clinical information provided, the request for left lumbar transforaminal epidural steroid injection is not recommended as medically necessary. The request is nonspecific and does not indicate the level/s to be injected. There is no comprehensive assessment of recent treatment completed to date or the injured worker's response thereto submitted for review to establish that she has been unresponsive to conservative treatment as required by Chronic Pain Medical Treatment Guidelines. There is no significant neurocompressive pathology on lumbar MRI.

LEFT LUMBAR TRANSFORAMINAL EPIDURAL STEROID INJECTION: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections Page(s): 46.

Decision rationale: Based on the clinical information provided, the request for left lumbar transforaminal epidural steroid injection is not recommended as medically necessary. The request is nonspecific and does not indicate the level/s to be injected. There is no comprehensive assessment of recent treatment completed to date or the injured worker's response thereto submitted for review to establish that she has been unresponsive to conservative treatment as required by Chronic Pain Medical Treatment Guidelines. There is no significant neurocompressive pathology on lumbar MRI.