

Case Number:	CM13-0020246		
Date Assigned:	10/11/2013	Date of Injury:	03/02/2013
Decision Date:	01/27/2014	UR Denial Date:	08/22/2013
Priority:	Standard	Application Received:	09/05/2013

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 Anesthesiology and Pain Medicine and is licensed to practice in 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 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 patient is a 48-year-old male who reported an injury on 03/02/2013. The clinical notes submitted for review indicates that the patient has complaints of pain verbalized as 9/10 VAS. The patient describes sharp, throbbing, dull, aching, pressure like pain and cramping as well as burning and pins and needle sensation to the low back and right leg. The notes indicate that the patient's mechanism of injury is a slip and fall on a wet floor. Treatment to date has consisted of 18 sessions of chiropractic treatment as of 07/15/2013 as well as treatment with a TENS unit and medications which included Ultram ER 150 mg, Naproxen 550 mg, and Prilosec 20 mg. An MRI of the lumbar spine was completed on 07/05/2013 which revealed at the requested level for injection of L5-S1 that the patient had a diffuse disc bulge of 4.2 mm with osteophytic changes compressing the thecal sac and bilateral transiting nerve roots and bilateral neural foraminal stenosis and compression of the bilateral exiting nerve roots as well as facet arthrosis resulting in bilateral neural foraminal stenosis. The notes indicate that on 08/07/2013 the patient underwent electrodiagnostic studies of bilateral lower extremities which revealed a normal EMG study of the lower extremities indicating no evidence for proximal lumbar radiculopathy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar epidural steroid injection, L5-S1: Overturned

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

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

Decision rationale: The California MTUS states that Epidural steroid injections (ESIs) are recommended as an option for treatment of radicular pain. The purpose of an ESI is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery. The criterion for injection includes but is not limited to radiculopathy documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). Injections should be performed using fluoroscopy (live x-ray) for guidance; with no more than two nerve root levels injected using transforaminal blocks and no more than one interlaminar level injected at one session. 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 six to eight weeks. The documentation submitted for review indicates that the patient has complaints of lower back and right hip pain. Physical examination of the lumbar spine reveals forward flexion at 40 degrees, extension at 15 degrees, and side bending at 25 degrees in either direction. Rotation is noted to be limited. Tenderness to palpation was noted over the bilateral lumbar paraspinal musculature consistent with spasms with no evidence of sciatic notch tenderness and no gluteal spasm or piriformis spasm. The patient as noted to have negative lumbar facet loading maneuvers bilaterally with negative Patrick's test and negative Gaenslen's maneuver. Examination of the bilateral knees revealed full range of motion with motor strength exhibiting normal bulk and tone and 5/5 graded strength throughout the upper and lower extremities with the exception of 4+/5 in the left ankle in plantar flexion and left great toe extension. The patient had diminished sensation in the left L5 and S1 dermatomes of the lower extremities with deep tendon reflexes indicated as symmetrical 1+/4 bilaterally. Given that the patient has undergone significant conservative treatment with medications as well as 18 sessions of chiropractic treatment and as imaging studies demonstrate at the requested level for injection that there is compression of the bilateral transiting and exiting nerve roots with clinical evaluation of the patient noting decreased range of motion, depressed reflexes, diminished sensation in the left L5 and S1 dermatomes of the lower extremities, 4+/5 strength of the left ankle in plantar flexion and great toe extension, the request for a lumbar epidural steroid injection, L5-S1 is medically necessary and appropriate.