

Case Number:	CM13-0022648		
Date Assigned:	03/19/2014	Date of Injury:	01/15/2000
Decision Date:	04/22/2014	UR Denial Date:	08/22/2013
Priority:	Standard	Application Received:	09/10/2013

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 & Rehabilitation has a subspecialty in Interventional Spine 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 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:

This patient reported a 1/15/2000 industrial injury claim. She was diagnosed with: right lumbar radiculopathy with neuroclaudication; HNP, lumbar; failed conservative therapies for pain control (PT, chiropractic, NSAID, muscle relaxants for more than 12 weeks). According to the 7/24/13 anesthesiology/pain management report from [REDACTED], the patient presents with 7/10 intractable low back pain and bilateral hip pain, right worse than left. The pain radiates to the RLE, with weakness, numbness and tingling. [REDACTED] states the SLR is positive on the right at 45 degrees and 60 degrees. There was weakness in the RLE I L4-5 myotomes. [REDACTED] recommends a right TFESI at L4-L5. On 8/22/13, UR recommended non-certification for the TFESI.

IMR ISSUES, DECISIONS AND RATIONALES

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

RIGHT LUMBAR TRANSFORAMINAL EPIDURAL STEROID INJECTION:

Overtured

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

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

Decision rationale: The Chronic Pain Medical Treatment Guidelines, ESIs, page 46 state that "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, with a general recommendation of no more than 4 blocks per region per year". According to the 7/24/13 anesthesiology/pain management report from [REDACTED], the patient presents with 7/10 intractable low back pain and bilateral hip pain, right worse than left. On exam, [REDACTED] notes positive SLR and weakness in the L4-L5 myotomes. MRI from 4/28/10 shows disc protrusions at L4/5 and L5/S1 abutting the L5 and S1 nerve roots bilaterally. The patient has had prior ESI in 2012 and the physician reported 50-70% improvement lasting over 6-weeks. The documentation provided for this IMR appears to meet the MTUS criteria for lumbar ESI.