MAXIMUS Federal Services

Case Number:	CM13-0028806		
Date Assigned:	11/01/2013	Date of Injury:	07/09/2012
Decision Date:	01/15/2014	UR Denial Date:	09/17/2013
Priority:	Standard	Application Received:	09/24/2013

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, was fellowship trained in Pain Medicine, and is licensed to practice in Texas and 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 patient is a 53-year-old male who reported a work-related injury on 7/9/12 as the result of strain to the lumbar spine. An MRI of the lumbar spine, dated 8/16/12 and signed by [redacted] revealed: (1) mild L4-5 vertebral body height loss with no evidence of acuity - it is unclear whether this represents remote traumatic changes or even congenital variant; (2) annular fissuring versus tear at L5-S1 with 6 mm left dorsal lateral L3-4 annular tear; and (3) no canal stenosis or neural foraminal narrowing at L2-3 through L5-S1, and severe at L4-5 and L5-S1. A clinical note dated 9/3/13 reports that the patient was seen under the care of [redacted], who documents that the patient has been treated conservatively with an exercise program, massage therapy, and topical analgesics. The patient was also seen in consultation to discuss spinal injection versus surgery. The patient has utilized physical therapy x5 months ago, in addition to a work hardening program; however, this did not resolve the patient's symptomatology. Upon physical exam of the patient, the provider documented tenderness across the low back primarily to the left side, tenderness upon the L3-4, L4-5, and L5-S1 segments (worse at L4-5), and a positive facet joint maneuver. Motor exam and sensation were intact. Deep tendon reflexes were depressed, but symmetrical. The patient had positive straight leg raise on the left causing radiating buttock pain.

IMR ISSUES, DECISIONS AND RATIONALES

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

The request for injection(s), anesthetic agent, and/or steroid, transforaminal epidural, with imaging guidance (fluoroscopy or CT), lumbar or sacral, single level: Upheld

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

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

Decision rationale: The clinical notes state that the patient had been treated under the care of [redacted] for lumbar spine pain complaints; he presented with a facet generated pain problem, and the provider recommended medial branch block/facet blocks. The patient subsequently underwent examination by a different provider, [redacted], who recommended transforaminal epidural steroid injections. The clinical notes state that the patient has utilized multiple conservative treatments, including physical therapy, massage therapy, and topical analgesics. Documentation of the patient's current medication regimen (aside from topical analgesics) was not stated. The most recent physical exam of the patient (dated 9/3/13) failed to show that the patient presented with any dermatomal deficits in a specific pattern with correlation to the imaging of the lumbar spine. California MTUS indicates, "Radiculopathy must be documented by physical exam and corroborated by imaging studies and/or electrodiagnostic testing." Given all of the above, the request is not medically necessary or appropriate.