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| Case Number: | CM13-0040218 | | |
| Date Assigned: | 06/20/2014 | Date of Injury: | 03/19/2012 |
| Decision Date: | 12/17/2014 | UR Denial Date: | 10/21/2013 |
| Priority: | Standard | Application Received: | 10/29/2013 |

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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Florida. 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 patient is a year 64 year old male who was injured on 3/19/2012. The diagnoses are lumbar radiculopathy, lumbar facet arthropathy and low back pain. The MRI of the lumbar spine showed multilevel disc bulge, neural foraminal narrowing and S1 root contact. The EMG/NCV in 2012 showed bilateral L5-S1 radiculopathy. On 4/15/2013 [REDACTED] / [REDACTED] PA noted subjective complaint of low back pain radiating to the lower extremities. There is associated numbness and tingling of the lower extremities. The pain score was 3/10 with medication and 5/10 without medications on a scale of 0 to 10. There was tenderness on the lumbar sacral area to palpation. There were no changes to motor, sensory and physical functional capacity. [REDACTED] noted a positive response from previous epidural injections but there was no quantifiable response noted. The available records show that the last lumbar epidural steroid injections were performed on 6/14/2013. The subsequent follow up notes did not include detailed effects of the epidural injections. The medications are gabapentin, Tramadol and Motrin for pain. A Utilization Review determination was rendered on 10/21/2013 recommending non-certification for Transforaminal epidural steroid injection using fluoroscopy at L4-5 and L5-S1.

IMR ISSUES, DECISIONS AND RATIONALES

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

Transforaminal Epidural Steroid Injection using Fluoroscopy L4-5: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of Epidural steroid injections Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Low Back

Decision rationale: The CA MTUS and the ODG guidelines recommend that lumbar epidural steroid injections can be utilized for the treatment of lumbar radiculopathy that did not respond to conservative treatment with medications and PT. The records indicate that the patient have subjective, objective and radiological findings consistent with lumbar radiculopathy. The records show that the subjective complaint of pain is well controlled with medications management and previous epidural steroid injections. The guidelines recommend that epidural steroid injections can be repeated if there is documented findings of greater than 70% pain relief with reduction in medications utilization and increase in physical function following the previous epidural injection. The post epidural injection documentation did not show these guidelines required documentations. The criteria for Transforaminal epidural steroid injection using fluoroscopy at L4-5 was not met.

Transforaminal Epidural Steroid Injection using fluoroscopy L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of Epidural steroid injections.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter Low Back

Decision rationale: The CA MTUS and the ODG guidelines recommend that lumbar epidural steroid injections can be utilized for the treatment of lumbar radiculopathy that did not respond to conservative treatment with medications and PT. The records indicate that the patient have subjective, objective and radiological findings consistent with lumbar radiculopathy. The records show that the subjective complaint of pain is well controlled with medications management and previous epidural steroid injections. The guidelines recommend that epidural steroid injections can be repeated if there is documented findings of greater than 70% pain relief with reduction in medications utilization and increase in physical function following the previous epidural injection. The post epidural injection documentation did not show these guidelines required documentations. The criteria for Transforaminal epidural steroid injection using fluoroscopy at L5-S1 was not met.