

Case Number:	CM13-0043767		
Date Assigned:	01/03/2014	Date of Injury:	10/17/2011
Decision Date:	03/27/2014	UR Denial Date:	10/22/2013
Priority:	Standard	Application Received:	10/31/2013

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, has a subspecialty in Pain Management and is licensed to practice in 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 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 female who reported injury on 10/17/2011. The mechanism of injury was noted to be a juvenile inmate who weighed approximately 200 pounds became agitated and ran into the patient with all of her force. The patient had immediate pain in the neck, right shoulder, low back, and knee. The patient had an MRI of the lumbar spine on 01/17/2012. The impression was noted to be there was a loss of intervertebral disc height and disc desiccation changes at L4-5 and L5-S1 levels with straightening of the normal lumbar spine lordosis and there was no paravertebral soft tissue abnormalities seen. There were annular concentric and broad-based slightly more to the left than right 2.8-3.2 mm disc protrusions present in combination with mild bilateral facet arthropathy changes producing mild to moderate bilateral spinal and neural foraminal stenosis with no extrusion or sequestration of the disc material. The patient was noted to have a prior lumbar epidural steroid injection which provided her with relief for 1 week. The patient had a positive straight leg raise bilaterally with referred back pain, left greater than right. The sensory testing for the lower extremities was grossly intact to pinwheel in all dermatomes and the myotome examination was within normal limits. The patient's diagnoses were noted to include cervical cord compression with left cervical radiculitis, left shoulder impingement, L5-S1 degenerative disc disease with possible radiculitis and chronic pain syndrome. The request was made for a lumbar spine epidural steroid injection at L5-S1.

IMR ISSUES, DECISIONS AND RATIONALES

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

lumbar spine epidural steroid injection at L5-S1: Upheld

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

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

Decision rationale: The California MTUS Guidelines recommend for repeat Epidural steroid injections, there must be 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. There was a lack of documentation of the above criteria for a repeat injection. Additionally, the patient had a normal dermatomal and myotomal examination. It was indicated that the patient had a positive straight leg raise bilaterally with referred back pain, left greater than right. The patient had a prior epidural steroid injection with one week of relief. Given the above, the request for a lumbar epidural steroid injection at L5-S1 is not medically necessary.