

Case Number:	CM13-0063091		
Date Assigned:	12/30/2013	Date of Injury:	04/19/2012
Decision Date:	04/18/2014	UR Denial Date:	11/12/2013
Priority:	Standard	Application Received:	12/09/2013

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 and Pain Medicine and is licensed to practice in Texas and Ohio. 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 43-year-old female who reported an injury on 04/19/2012. The mechanism of injury was noted to be a motor vehicle accident. The patient is diagnosed with lumbar spine strain, right sacroiliac strain, and radicular symptoms. Her most recent office note dated 12/06/2013 indicated the patient reported intermittent moderate low back pain with radiation to her knees bilaterally, as well as numbness in her legs bilaterally. Her objective findings included tenderness to palpation, decreased sensation to light touch at right L4, and positive straight leg raise testing. The records include electrodiagnostic studies which revealed evidence of a bilateral L5 and S1 lumbosacral radiculopathy. Her MRI was noted to reveal a disc protrusion at the L5-S1 level with no evidence of neural foraminal narrowing. Office note dated 09/19/2013 indicated that the patient received an epidural steroid injection 2 weeks earlier and reported 15% improvement. At her follow-up visit on 10/17/2013, it was noted the patient reported a 40% relief of symptoms since her epidural steroid injection, but the pain returned. Recommendations were made at her 10/04/2013 and 10/17/2013 office visits for repeat epidural steroid injections. However, it is noted in her 12/06/2013 office note that the patient was not interested in another epidural steroid injection due to side effects.

IMR ISSUES, DECISIONS AND RATIONALES

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

The REQUEST FOR AN L5-S1 EPIDURAL STEROID INJECTION: 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 Epidural steroid injections (ESIs) Page(s): 46.

Decision rationale: As the CA MTUS guidelines have not addressed the revision of fusion and decompression of pseudoarthrosis of L3-S1, other medical guidelines were consulted. According to the ACOEM guidelines, spinal fusion is recommended for cases of trauma-related spinal fracture or dislocation, fusion of the spine otherwise it is not usually considered. The Global Spine Journal recommend: careful assessment to determine the exact cause of symptoms and the effect on the patients' emotional and functional state is paramount in revision back surgery. Patients should undergo a detailed history and physical examination to rule out non-spinal causes for their current symptoms and to identify their pain generator. Such an approach can help with the preoperative planning, avoid any unexpected intra-operative findings, and improve the outcome after surgery. The medical records document the patient had complained of more elevated pain level and increased radicular complains that had involved both legs, the pain was exaggerated with movement, the patient experienced a giving way sensation of the leg while walking. The patient denied any bladder or bowel dysfunction. Objectively the patient had no foot drop in gait evaluation, the patient had difficulty to rise from the chair, there was a moderately restriction in all range of motion. In the absence of documented recent complete neurological examination, absence of plain x-ray of lumbar spine including the dynamic views, absence of recent CT (computed tomography) lumbar spine, and absence of recent MRI (magnetic resonance imaging), the request is not medically necessary according to the guidelines.