

Case Number:	CM13-0070024		
Date Assigned:	01/03/2014	Date of Injury:	09/15/1999
Decision Date:	05/20/2014	UR Denial Date:	12/13/2013
Priority:	Standard	Application Received:	12/24/2013

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 Pain Medicine 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:

The patient is a 60 year old male who was injured on 09/15/1999. The mechanism of injury is unknown. Prior treatment history has included epidural injections 07/11/2013. The patient underwent right and left carpal tunnel surgeries and left arthroscopic knee surgery. Diagnostic studies reviewed include MRI of the lumbar spine dated 01/13/2011 showing a broad-based disc protrusion at T12-L1. At L3-L4 there are hypertrophic changes of the facet joints with hypertrophy of ligamentum flavum. There is a 5 mm left posterolateral disc protrusion/extrusion encroaching into the left neural foramen with moderately significant narrowing of the left neural foramen. This level shows a moderate degree of central stenosis. At T4-L5 there is a mild degree of central stenosis secondary to a combination of hypertrophic changes of the facet joints, hypertrophy of ligamentum flavum and 5 mm of anterolisthesis of L5 over L5. This level shows obliteration of the lateral recesses and marked narrowing of both neural foramen. The L5-S1 reveals posterolateral disc/end plate configuration appears to be normal. The neural foramina and subarticular gutters appear to be intact. PR-2 dated 12/05/2013 documented the patient with complaints of low back pain that radiates to the right lower extremity. The patient also complains of left neck pain that radiates to bilateral upper extremities. The patient's pain level is increased with average pain level of 9/10 with medications and 10/10 without medications. The patient is status post lumbar spine epidural steroid infusion at L3-5 level on 07/11/2013. Post procedure the patient reports good (50-80%) overall improvement. The duration of improvement was 3+ months. Objective findings on exam included the patient's gait was antalgic and slow assisted with the use of a cane. The range of motion of the lumbar spine revealed moderate reduction secondary to pain. Pain was significantly increased with flexion and extension. Spinal vertebral tenderness was noted in the lumbar spine at the L4-S1 level. Lumbar myofascial tenderness was noted on palpation. Sensory examination showed increased touch in the right lower extremity.

Decreased sensation was noted along the right L4 dermatome. Straight leg raise with the patient in the seated position and the leg fully extended was positive on the bilateral lower extremities for radicular pain at 70 degrees.

IMR ISSUES, DECISIONS AND RATIONALES

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

AN L3-L4 LUMBAR EPIDURAL INJECTION WITH FLUOROSCOPY: Upheld

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

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

Decision rationale: According to the medical records provided for this review, this patient underwent a previous lumbar epidural steroid injection on 7/11/2013. According to the 12/5/2013 report, he has obtained 50-80% reduction in pain for more than three months. He reports pain rated 9/10 with medications and 10/10 without on that date. However, the medical records do not substantiate the patient obtained optimum pain relief and improved function as result of the prior injection. The medical records do not demonstrate that the patient's medication use was decreased or function improved. Also, the medical report dated 8/2/2013, documents the patient reported pain reduction of 9/10 to 7/10, three weeks post-injection, and 7/10 pain level was also reported in the 9/5/2013 medical report. The medical records do not document reduction in medication or improvement in function. The guidelines state therapeutic 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 week. The medical records do not establish adequate benefit from the prior epidural injection, consequently, a repeat injection would not be recommended.