

Case Number:	CM13-0070645		
Date Assigned:	01/08/2014	Date of Injury:	09/12/2011
Decision Date:	06/05/2014	UR Denial Date:	12/06/2013
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 Occupational 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 an employee of [REDACTED] and has submitted a claim for low back pain associated with an industrial injury date of September 12, 2011. Treatment to date has included medications, physical therapy, chiropractic treatment, acupuncture, and interbody fusion at L4-5 and L5-S1. Medical records from 2012 through 2013 were reviewed, which showed that the patient complained of low back pain with moderate to severe left radicular leg pain, numbness, tingling, and weakness. Physical examination showed diminished range of motion of the lumbar spine on all planes. Straight leg raising resulted to pain at the back and left leg. Motor testing showed weak left gastrocnemius and left extensor hallucis longus. Sensation was intact. Electromyography of the lower extremities, dated 10/01/13, showed evidence of bilateral chronic active bilateral L5-S1 radiculopathy. An MRI of the lumbar spine, dated 09/22/2013, revealed disc desiccation at L4-L5 with diffuse disc protrusion with annular tear effacing the thecal sac. At the L5-S1 level, there was focal central disc protrusion with annular tear effacing the thecal sac. L4 and L5 exiting nerve roots were unremarkable. A utilization review from December 6, 2013 denied the request for left transforaminal epidural steroid injection at L4-5 and L5-S1 because the documentation did not describe functional benefit and duration of effect following prior epidural steroid injections. An appeal dated December 17, 2013 indicated that the patient never received an epidural steroid injection since her surgery and that the patient has failed post-operative physical therapy, rest, and activity modification.

IMR ISSUES, DECISIONS AND RATIONALES

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

LEFT TRANSFORAMINAL EPIDURAL STEROID INJECTION AT L4-5 AND L5-S1:
Overturned

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

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

Decision rationale: According to page 46 of the MTUS Chronic Pain Guidelines, epidural injections are not supported in the absence of objective radiculopathy. In addition, criteria for the use of epidural steroid injections include an imaging study or electrodiagnostic tests documenting correlating concordant nerve root pathology and unresponsiveness to conservative treatment (exercises, physical methods, NSAIDs, and muscle relaxants). In this case, the medical records showed that the patient has failed previous treatment regimens such as lumbar fusion, physical therapy, chiropractic care, acupuncture, and medications. The patient still has persistent low back pain radiating to the left lower extremity with objective findings of radiculopathy, confirmed by electrodiagnostic studies and MRI. The MTUS Chronic Pain Guidelines criteria have been met. Therefore, the request is medically necessary and appropriate.