MAXIMUS Federal Services

Case Number:	CM14-0002765		
Date Assigned:	04/04/2014	Date of Injury:	07/14/1998
Decision Date:	05/27/2014	UR Denial Date:	01/06/2014
Priority:	Standard	Application Received:	01/08/2014

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 injured worker is 58-year-old female who was involved in a work-related injury on July14, 1998. Diagnosis for lumbar spondylosis at L4-5 & L5-S1 and spondylolisthesis at L4-5 with stenosis were established and treated under conservative measures, including medication management, physical & aquatic therapy, injection therapy (non-ESI), and home/gym exercise protocols. Work status is reported as retired. Medical records dated on 1/24/14 notate lower back pain with right calve muscle pain. Examinee reported to ER and was treated with injection of unknown type, which did not provide any substantial relief of symptoms. Examination reports unremarkable with regards to root tension signs and is neurologically intact. Radiculopathy is not established on examination and is the condition is reported as permanent and stationary. Injured worker is referred to pain specialist for possible radiofrequency ablation, given prescription medication for symptom control, and is requesting use of ESI at L4-5.

IMR ISSUES, DECISIONS AND RATIONALES

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

EPIDURAL STEROID INJECTION AT L4-5 QTY:1.00: Upheld

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

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

Decision rationale: The MTUS Chronic Pain treatment guidelines, ESI section pg. 46, indicate the request for epidural steroid injection at L4-5. Guidelines indicate the purpose of ESI is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. The medical records from 01/24/14 report essentially no change in subjective complaints or in examination findings as from prior report dated 12/27/13. Examination findings include lumbar range of motion as 90-degree forward flexion, 20-degree extension, and 30 degree with lateral bending, which are essentially full and within normal limitations. There were no root tension signs reported on exam and neurological findings for the lower extremities were intact for motor and sensation. No atrophy was noted on exam. The condition was documented as permanent and stationary and a referral for pain medication was given along with referral for pain specialist for possible radiofrequency ablation for diagnosis of spondylosis at L4-5 & L5-S1 and spondylolisthesis at L4-5 with stenosis based on imaging from over 10 years old. Radiculopathy has not been established, and therefore the request does not meet guideline criteria for ESI injection. Based on the MTUS Chronic Pain treatment guidelines and criteria as well as the clinical documentation stated above, the request for epidural steroid injection at L4-5 is not medically necessary and appropriate.

PAIN MANAGEMENT REFERRAL QTY: 1.00: Overturned

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation NON-MTUS.

MAXIMUS guideline: Decision based on MTUS ACOEM,Chronic Pain Treatment Guidelines (Chronic Pain Programs) Page(s): 127 and 31-32.

Decision rationale: Per ACOEM/Chronic pain Medical Treatment Guidelines, This is a request for specialist referral. Referral may be indicated where the course of care may benefit from additional expertise. In this case the patient has significant lumbar pathology with chronic pain that could respond favorably to additional measures. Medical necessity is established, and the request is medically necessary and appropriate.