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| Case Number: | CM14-0007534 | | |
| Date Assigned: | 02/10/2014 | Date of Injury: | 06/08/2012 |
| Decision Date: | 07/07/2014 | UR Denial Date: | 12/21/2013 |
| Priority: | Standard | Application Received: | 01/21/2014 |

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 Anesthesiology, has a subspecialty in Pain Management, 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 35-year-old male who has submitted a claim for Left Testicular Pain of Unknown Origin associated with an industrial injury date of June 8, 2012. Medical records from 2013 were reviewed, which showed that the patient complained of severe left testicular pain. On physical examination, the abdomen was soft, non-tender, and non-distended. The phallus was uncircumcised. There were no inguinal hernias or testicular tenderness. A small left varicocele was appreciated. Digital rectal exam was unremarkable. MRI of the lumbar spine dated December 19, 2013 revealed no marked central canal narrowing or marked lateral recess or foraminal encroachment at any lumbar level. At the L3-4 level, annular tears were noted in close proximity to the foraminal L3 root sleeves and could represent a chemical source of L3 nerve root irritation. Treatment to date has included medications, bilateral inguinal herniorrhaphy, two sessions of physical therapy, and cord block. Utilization review from December 19, 2013 denied the request for inject spine lumbar/sacral because further specialist evaluation should take place before medical necessity of the requested procedure can be established.

IMR ISSUES, DECISIONS AND RATIONALES

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

INJECT SPINE LUMBAR/SACRAL: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792.24.2, Epidural Steroid Injections Page(s): 46.

Decision rationale: According to page 46 of the CA MTUS Chronic Pain Medical Treatment Guidelines, criteria for the use of epidural steroid injections include: (1) an imaging study documenting correlating concordant nerve root pathology; (2) unresponsiveness to conservative treatment; and (3) if used for diagnostic purposes, a maximum of two injections should be performed. In this case, epidural steroid injection was requested for diagnostic purposes. The requesting physician noted that the most likely cause of the testicular pain was irritation of the L3 nerve root sleeves from annular tears and a transforaminal epidural steroid injection will provide information if this theory was correct. In addition, the patient underwent urology consultation, wherein the recommendations given were spermatic cord denervation, orchiectomy, or pain management clinic. The patient had pain management consultation and findings showed that the patient's presentation was very consistent with a left ilioinguinal neuralgia likely either from scar tissue or from some trauma related to the hernia itself. Thus, there are conflicting statements regarding the etiology of the patient's testicular pain. Furthermore, the present request failed to specify the site and the number of injections to be administered. The criteria were not met. Therefore, the request for INJECT SPINE LUMBAR/SACRAL is not medically necessary.