

Case Number:	CM14-0008015		
Date Assigned:	02/12/2014	Date of Injury:	01/02/2013
Decision Date:	06/30/2014	UR Denial Date:	01/07/2014
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 Orthopedic Surgery and is licensed to practice in Texas. 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 a 63 year old male whose date of injury is 01/02/2013. There is reportedly no specific injury, but the injured worker developed lower back pain and numbness of the right foot secondary to sitting at work for a prolonged period of time. Lumbar MRI dated 01/25/13 revealed at L3-4 there is a 3mm left lateral extruded disc herniation with a peripheral annular tear contributing to moderate to severe left L4 lateral recess stenosis and minimal central canal stenosis. There is a far lateral bulge in the annulus with minimal to moderate left and minimal right foraminal stenosis. There are lateral annular fissures and minor anterior spondylosis. Treatment to date includes medication management, at least 30 sessions of physical therapy, acupuncture, x-rays and MRI. The injured worker underwent right L3-4 and left L4-5 transforaminal epidural steroid injection on 11/07/13. Follow up evaluation dated 11/22/13 documents 50% pain reduction after the injection. Lumbar MRI dated 12/27/13 revealed at L3-4 there is a 2 mm posterior disc bulge causing mild thecal sac narrowing. There is moderate to severe bilateral lateral recess narrowing and mild right and moderate left neural foraminal narrowing. EMG/NCV dated 01/07/14 revealed evidence of a right chronic S1 radiculopathy. Orthopedic evaluation dated 01/21/14 indicates that the epidural steroid injection provided 50% relief for one to two months. On physical examination straight leg raising is negative. There is decreased sensation in the toes of the right foot.

IMR ISSUES, DECISIONS AND RATIONALES

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

TRANSFORAMINAL LUMBAR EPIDURAL STEROID INJECTIONS OF THE LEFT L3-4: Upheld

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: Based on the clinical information provided, the request for transforaminal lumbar epidural steroid injections of the left L3-4 is not recommended as medically necessary. The injured worker underwent right L3-4 and left L4-5 transforaminal epidural steroid injection on 11/07/13. The injured worker does not have any neurological deficits documented in the left lower extremity to support a left L3-4 epidural steroid injection. Additionally, straight leg raising is noted to be negative. EMG/NCV noted evidence of right chronic S1 radiculopathy. CA MTUS guidelines require documentation of radiculopathy on physical examination corroborated by imaging studies and/or electrodiagnostic results. Therefore, the request is not medically necessary.

POST-EPIDURAL PHYSICAL THERAPY 2 X 8 WEEKS FOR THE LUMBAR SPINE: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, PHYSICAL MEDICINE,

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter, Physical medicine treatment

Decision rationale: Based on the clinical information provided, the request for post-epidural physical therapy 2 x 8 weeks for the lumbar spine is not recommended as medically necessary. First, the requested epidural steroid injection is non-certified, and therefore post-injection physical therapy is not supported. Additionally, the request is excessive as the Official Disability Guidelines would support 1-2 sessions of post-injection physical therapy.