

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM14-0104063 | | |
| Date Assigned: | 09/24/2014 | Date of Injury: | 06/26/2012 |
| Decision Date: | 10/24/2014 | UR Denial Date: | 06/16/2014 |
| Priority: | Standard | Application Received: | 07/07/2014 |

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 Physical Medicine and Rehabilitation 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:

Patient is a 50-year-old female who has submitted a claim for lumbar spondylosis, lumbar radiculopathy, and facet syndrome associated with an industrial injury date of 6/26/2012. Medical records from 2013 to 2014 were reviewed. The patient complained of low back pain radiating to the left lower extremity. Aggravating factors included bending, reaching, and prolonged positioning. Pain was rated 7/10 in severity. Physical examination of the lumbar spine showed tenderness, muscle spasm, and restricted motion. Muscle strength of left extensor hallucis longus was rated 4+/5. Sensation was diminished at the left lower extremity. Straight leg raise test was positive on the left. MRI of the lumbar spine, dated 7/1/2013, demonstrated small disc bulge at L5 to S1 with a high intensity zone centrally without spinal canal or neural foramina stenosis. Treatment to date has included transforaminal epidural steroid injection at L5 to S1 and nerve block at L5 on 12/7/2012, left sacroiliac joint injection on 9/18/2013, physical therapy, and medications. Utilization review from 6/16/2014 denied the request for left L5-S1 transforaminal epidural injection because the guideline did not support repeat injections when the initial injection provided no relief. Because of non-certification of epidural steroid injection, all the other requests, i.e., moderate Sedation, Injection Procedure For Myelography And/Or Computed Tomography, Myelography, Lumbosacral, Radiological Supervision and Interpretation, and Epidurography Radiological Supervision and Interpretation were also not certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left L5-S1 Transforaminal Epidural Injection: 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 Page(s): 46.

Decision rationale: As stated on page 46 of CA MTUS Chronic Pain Medical Treatment Guidelines, epidural steroid injection (ESI) is indicated among patients with radicular pain that has been unresponsive to initial conservative treatment. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 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 weeks. In this case, patient complained of low back pain radiating to the left lower extremity. Aggravating factors included bending, reaching, and prolonged positioning. Pain was rated 7/10 in severity. Physical examination of the lumbar spine showed tenderness, muscle spasm, and restricted motion. Muscle strength of left extensor hallucis longus was rated 4+/5. Sensation was diminished at the left lower extremity. Straight leg raise test was positive on the left. Clinical manifestations were consistent with radiculopathy. However, MRI of the lumbar spine, dated 7/1/2013, demonstrated small disc bulge at L5 to S1 with a high intensity zone centrally without spinal canal or neural foramina stenosis. There was no evidence of nerve root impingement based on the imaging report. Moreover, patient underwent transforaminal epidural steroid injection at L5 to S1 and nerve block at L5 on 12/7/2012. There was no documentation concerning percentage and duration of pain relief. Guideline criteria are not met. Therefore, the request for Left L5-S1 Transforaminal Epidural Injection is not medically necessary.

Moderate Sedation: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: The related request for Left L5-S1 Transforaminal Epidural Injection has been deemed not medically necessary; therefore, all of the associated services, such as this request for moderate sedation is likewise not medically necessary.

Injection Procedure For Myelography And/Or Computed Tomography:

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: The related request for Left L5-S1 Transforaminal Epidural Injection has been deemed not medically necessary; therefore, all of the associated services, such as this

request for Injection Procedure For Myelography And/Or Computed Tomography is likewise not medically necessary.

Myelography, Lumbosacral, Radiological Supervision and Interpretation: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: The related request for Left L5-S1 Transforaminal Epidural Injection has been deemed not medically necessary; therefore, all of the associated services, such as this request for Myelography, Lumbosacral, Radiological Supervision and Interpretation is likewise not medically necessary.

Epidurography Radiological Supervision and Interpretation: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: The related request for Left L5-S1 Transforaminal Epidural Injection has been deemed not medically necessary; therefore, all of the associated services, such as this request for Epidurography Radiological Supervision and Interpretation is likewise not medically necessary.