

Case Number:	CM14-0012856		
Date Assigned:	02/24/2014	Date of Injury:	11/28/2012
Decision Date:	08/04/2014	UR Denial Date:	01/16/2014
Priority:	Standard	Application Received:	01/31/2014

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 and Washington State. 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 43-year-old female who reported an injury on 11/28/2012. The mechanism of injury was noted to be the injured worker slipped and fell. The injured worker's prior treatments were noted to be medications and surgical intervention. The injured worker's diagnosis was noted to be lytic spondylolisthesis at L5-S1, postoperative left lower extremity radicular symptoms, L5-S1 stenosis, and status post L5-S1 Gil laminectomy. A clinical evaluation on 12/30/2013 noted the injured worker with complaints of low back pain rated a 7/10 that radiated into her left buttock and down her posterior thigh through the calf, rated an 8/10. She indicated she did have some ongoing right leg pain rated a 6/10. The injured worker's physical examination noted decreased sensation over the left L5 and S1 dermatome distribution, absent deep tendon reflex to the right ankle, and diminished strength in the left ankle with dorsiflexion. The injured worker had a positive straight leg raise at 60 degrees. A review of a CT scan of the lumbar spine indicated no evidence for vertebral body fracture or scoliosis. The treatment plan included a request for a pain management consultation and a left sided L5-S1 transforaminal epidural steroid injection. The provider's rationale for the requested ESI and pain management consult were both provided within the documentation. A Request for Authorization for medical treatment was not provided within the documentation provided for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

L5-S1 transforaminal epidural steroid injection: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, ESI.

Decision rationale: The California MTUS/American College of Occupational and Environmental Medicine state that invasive techniques (local injections and facet joint injections of cortisone and lidocaine) are of questionable merit. Although epidural steroid injections may afford short-term improvement in leg pain and sensory deficits in injured workers with nerve root compression due to a herniated nucleus pulposus, this treatment offers no significant long-term functional benefit, nor does it reduce the need for surgery. The Official Disability Guidelines recommend epidural steroid injections as a possible option for the short-term treatment of radicular pain (defined as pain in a dermatomal distribution with corroborative findings of radiculopathy) with use in conjunction with active rehab efforts. The purpose of an epidural steroid injection is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, reduction of medication use and avoiding surgery; but this treatment alone offers no significant long-term functional benefit. The criteria for an epidural steroid injection, according to the guidelines, are: radiculopathy must be documented; objective findings on examination need to be present; the injured worker must be initially unresponsive to conservative treatment of exercise, physical methods, NSAIDs and muscle relaxants; and injections should be performed using fluoroscopy and injection of contrast for guidance. The guidelines continue to recommend that no more than 2 nerve root levels should be injected using transforaminal blocks. The clinical evaluation does not indicate that there is a rehab effort in place, including a home exercise program. The physical examination does not provide a significant case for radiculopathy. The evaluation lacks myotomal weakness, diminished deep tendon reflexes and significant decreased sensation. The documentation fails to provide an official MRI to indicate disc bulge or nerve root compression. Therefore, the request for an L5-S1 transforaminal epidural steroid injection is not medically necessary.

Pain management consult: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation ACOEM guidelines, chapter 7, pg. 127.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, office visits.

Decision rationale: The Official Disability Guidelines recommend office visits as determined to be medically necessary. Evaluation and management outpatient visits to the offices of medical doctors play a critical role in the proper diagnosis and return to function of an injured worker, and they should be encouraged. The need for clinical office visits with a healthcare provider is individualized based upon a review of the injured worker's concerns, signs and symptoms, clinical stability and reasonable physician judgment. In this case, the clinical evaluation lacks an

adequate pain assessment. It is not noted if the current medications provides efficacy. Therefore, the request for a pain management consult is not medically necessary.