

Case Number:	CM14-0018386		
Date Assigned:	04/18/2014	Date of Injury:	01/27/2013
Decision Date:	06/30/2014	UR Denial Date:	01/30/2014
Priority:	Standard	Application Received:	02/13/2014

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 Family Medicine and is licensed to practice in Arizona. 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 49 year old with a date of injury on 1/27/2013. Patient has been treated for ongoing symptoms in his thoracic back. Subjective complaints are of severe, continuous aching/stabbing pain in the back that is worse in the evenings. Physical exam shows tenderness to the right side paraspinal muscles, and increased pain with inspiration. There is documented radiation of pain around to the anterior chest at T9-10. Patient had normal reflexes, strength and sensation. Medications include Motrin and Flexeril. Other treatments have included 12 physical therapy sessions without improvement. Patient has a history of L5-S1 fusion in 11/2011. Diagnostic studies include a thoracic spine MRI on 1/19/2013 which showed small right sided disc protrusion at T9-10 without definite cord compression. CT scan of thoracic spine on 5/1/2013 was inconclusive.

IMR ISSUES, DECISIONS AND RATIONALES

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

EPIDURAL STEROID INJECTION TO THE RIGHT T9-10 NERVES: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES, CRITERIA FOR THE.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines MTUS: CHRONIC PAIN MEDICAL TREATMENT GUIDELINES PHYSICAL MEDICINE, , 46.

Decision rationale: The CA MTUS notes that 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. While for diagnostic purposes, a maximum of two injections can be performed if there is inadequate response to the first block. Criteria for epidural steroid injections must show documented radiculopathy on physical exam and corroborated by imaging studies and/or electrodiagnostic testing. This patient has thoracic back pain documented, and records establish a physical exam consistent with an active radiculopathy. Furthermore, the record indicates MRI findings of a herniated disc in the corresponding area. Therefore, the request for epidural steroid injection is consistent with guidelines and is medically necessary.