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| Case Number: | CM14-0110176 | | |
| Date Assigned: | 08/01/2014 | Date of Injury: | 10/12/2011 |
| Decision Date: | 09/09/2014 | UR Denial Date: | 06/24/2014 |
| Priority: | Standard | Application Received: | 07/15/2014 |

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 Emergency Medicine 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 has a reported date of injury on 10/12/2011. Mechanism of injury was no provided for review. Patient has a diagnosis of Post-concussive headache, right (R) wrist pain post-surgery from fracture and ligamentous injury, myofascial sprain and strain of lumbosacral spine, degenerative joint disease of lumbosacral spine, lumbar stenosis and left (L) knee pain post arthroscopic surgery for ACL tear. Medical records reviewed. Last report available until 7/28/14. Patient (pt) complains of low back pain. Pain is 9/10. Medication improves pain to 6-7/10. Pt also has complains of R wrist and L knee pains. Objective findings reveal normal lordosis. Tenderness to lumbosacral spine and paraspinal muscles. No stiffness or spasms. There was no noted straight leg raise. No advance imaging or electrodiagnostic studies were provided for review. No medication list was provided. Patient is noted to be on prilosec and ibuprofen. Pt had a reported ESI of L5-S1 on 2/2013 with reported 40% improvement. Independent Medical Review is for Transforaminal Epidural Steroid Injection L5-S1. Prior UR on 6/30/14 recommended non-certification.

IMR ISSUES, DECISIONS AND RATIONALES

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

Transforaminal ESI left L5-S1: 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 Injections (ESIs) Page(s): 46.

Decision rationale: As per MTUS Chronic Pain Guidelines, Epidural Steroid Injections (ESI) may be useful in radicular pain and may be recommended if it meets criteria. The basic criteria are: 1) Goal of ESI: ESI has no long term benefit. It can decrease pain in short term to allow for increasingly active therapy or to avoid surgery. The documentation states that the ESI was to decrease pain. There is noted long term plan. Fails criteria.2) Unresponsive to conservative treatment. There is no proper documentation of prior attempts at treatment of pain. There is no medication list provided for review. Fails criteria.3) Documentation of improvement in objectively documented pain after prior ESI of at least 50% in pain lasting 6-8weeks. Fails criteria. Only 40% improvement was documented.As clearly stated in MTUS Chronic pain guidelines, patient has to meet all criteria before ESI can be recommended. The treating physician has failed to document any significant response to prior ESI. The failure to document prior conservative measures and long term goal of treatment also fails to meet criteria. The request and documentation does not meet criteria and ESI is not medically necessary.