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| Case Number: | CM14-0155729 | | |
| Date Assigned: | 09/25/2014 | Date of Injury: | 11/18/2008 |
| Decision Date: | 10/28/2014 | UR Denial Date: | 09/12/2014 |
| Priority: | Standard | Application Received: | 09/23/2014 |

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 Fellowship Trained in Emergency Medical Services 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 60-year-old female who reported an injury on 11/18/2008. The mechanism of injury was not provided. The surgical history included a spine surgery. The injured worker underwent a lumbar facet joint injection at L3-4. The injured worker's medications included estradiol, Lyrica, Norco, Celexa, Skelaxin and a fentanyl patch. The injured worker underwent a CT scan of the lumbar spine on 04/01/2014 which revealed at the left of L3-4 there was a broad-based posterior disc osteophyte complex. There was bilateral facet hypertrophy and ligamentum flavum thickening. There was moderate to severe canal stenosis with AP canal diameter approximately 6 mm. The injured worker underwent surgical intervention for the lumbar spine. The injured worker underwent an MRI of the lumbar spine on 07/02/2014 which revealed at the level of L3-4 there was diffuse annular bulging. There was bilateral facet and ligamentum flavum hypertrophy. There was fluid within the right and left L3-4 facet joints. There was narrowing of the lateral recesses. There was moderate to severe canal stenosis that was stable from 01/24/2013 and there was bilateral foraminal narrowing at L3-4 that was stable from 01/24/2013. The documentation of 09/04/2014 revealed the injured worker got relief from the lumbar foraminal joint injection at L3-4. The physical examination revealed the injured worker had severe tenderness in the left sciatic notch, right sciatic notch, and bilateral lower lumbar paraspinal muscles. The injured worker's strength and sensation was intact and was 5/5. The injured worker had a moderate antalgic gait. The diagnoses included failed back surgery syndrome, spinal stenosis without neurogenic claudication and lumbosacral spondylosis without myelopathy as well as radiculitis. The treatment plan included the transforaminal epidural steroid injection at L3-4 and a refill of medications. The rationale was stated to be after the face injections, per prior discussion, the physician would work on the injured worker's leg pain. There was a Request for Authorization submitted to support the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Transforaminal injection at bilateral L3-L4: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs).

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

Decision rationale: The California MTUS Guidelines recommend epidural steroid injections when there is documentation of objective findings of radiculopathy that are corroborated by electrodiagnostic testing or imaging studies. There should be documentation the injured worker's pain is initially unresponsive to conservative care including physical medicine treatment, NSAIDS and muscle relaxants. The clinical documentation submitted for review failed to provide objective findings of radiculopathy at the requested level. The MRI failed to indicate the injured worker had nerve impingement. There was a lack of documentation indicating the injured worker had a failure of conservative care and what conservative care consisted of. Given the above, the request for transforaminal injection at bilateral L3-4 is not medically necessary.