

Case Number:	CM14-0022705		
Date Assigned:	06/11/2014	Date of Injury:	03/18/2012
Decision Date:	07/15/2014	UR Denial Date:	01/23/2014
Priority:	Standard	Application Received:	02/24/2014

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 Alabama. 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 patient is a 66 year old male who was injured on 03/18/2012 while he was on a ladder he turned and fell twisting his back as he grabbed the railing. Prior treatment history has included the following medications: aspirin, ibuprofen, Lunesta, Synthroid, Tramadol, Lyrica and holistic poppy seed extract. He has had ESI. Diagnostic studies reviewed include MRI of the lumbar spine 08/16/2013 revealed L4-L5 diffuse disc bulge with a canal diameter of 11 mm, at L5-S1 there is a 3 mm disc bulge with moderate right side foraminal narrowing and moderate left side foraminal narrowing. Central canal diameter is 10 mm. Annular tearing is noted to be present in the peripheral disc with ligament hypertrophy. Progress note dated 12/05/2013 documented the patient with lumbar pain primarily to the right lower extremity and both for extremities present lower discomfort. Since the last LESI the patient states left side pain improved significantly by 80% and the right side improved by 50%. Objective finding son examination the patient's height is 5'9 with weight at 228 pounds. He has thoracic kyphosis with reduction of lumbar lordosis. Muscle spasm is present from L2 to sacrum. Bilateral range of motion is normal. Lumbar flexion is 20 %, extension 10 %, lateral bending 10%. Diagnoses: Bilateral L-5 and possible right S1 radiculopathy. This injury at L4 to L5 and L5-S1 with foraminal stenosis. Utilization report dated 01/23/2014 request lumbar epidural steroid injections at L4-5 and S1 nerve root on the right. This request was not certified due to medical necessity has not been established for this request.

IMR ISSUES, DECISIONS AND RATIONALES

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

LUMBAR EPIDURAL STEROID INJECTIONS AT L4-5, AND S1 NERVE ROOTS ON THE RIGHT: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM, Chronic Pain Treatment Guidelines Epidural Steroid Injections.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Epidural steroid injections.

Decision rationale: Based on the above guidelines for epidural steroid injections, in the therapeutic phase, 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, the patient underwent Lumbar Epidural Steroid Injection (LESI) at bilateral L5/S1 on 10/16/13. Per note by [REDACTED] on 12/5/13 "since last visit had LESI bilaterally, reports left side improved significantly (80%), right side also improved but still with significant symptoms (50%). The documentation for "at least 50% pain relief" is present, however there is no additional documentation of functional improvement with associated reduction of medication use for six to eight weeks. In addition, per ODG guidelines above, "Indications for repeat blocks include acute exacerbation of pain, or new onset of radicular symptoms." However, the note by [REDACTED] on 12/5/13 does not document any "acute exacerbation of pain, or new onset of radicular symptoms," rather reports he "has ongoing persistent symptoms of numbness and pain right lateral leg, right foot and toes, to include sole of the foot." Therefore, based on the above guidelines and criteria as well as the clinical documentation stated above, the request is not medically necessary.