

Case Number:	CM14-0031560		
Date Assigned:	06/20/2014	Date of Injury:	01/05/1998
Decision Date:	07/17/2014	UR Denial Date:	02/27/2014
Priority:	Standard	Application Received:	03/12/2014

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 with reported date of injury on 1/5/1998. No mechanism of injury was provided. Patient has a diagnosis of L4-5 disc extrusion, thoracic/lumbosacral neuritis/radiculitis, depression and lumbago. Medical records from primary treating physician and consultants reviewed. Last report available until 3/3/14. Patient complains of low back pain. Pain is 6-9/10. Pain has been worsening and pain medications are less effective. Pt also complains of depression and low mood. Objective exam reveals antalgic gait, with R trendelenburg gait pattern. Lumbar spine exam reveals limited range of motion (ROM) with very limited ROM in all direction. Tenderness noted in paravertebral muscles, tenderness and tight muscle band on both sides. Spinous process tenderness on L4-5. Pt is not able to walk on toes. Positive straight leg raise on both sides. Diffusely decreased deep tendon reflexes. Neurologic exam is significant for 4/5 strength in gastrocnemius and tibialis anterior bilaterally. Decreased light touch over L5 and S1. MRI of Lumbar spine (10/3/13) reveals moderate diffuse spondylosis with hypertrophic facet changes posteriorly causing mild central stenosis from L2-3 and L4-5, moderate bilateral L5-S1 neural foraminal impingement and reabsorption of previous disc protrusion. Current medication include cialis, sertraline, hydrocodone/acetaminophen and ibuprofen. Prior therapy include physical therapy, pain medications and antidepressants. Was previously on gabapentin which was not effective. Pt had declined surgery on January 2012. Utilization review is for lumbar epidural steroid injection. Prior UR on 2/27/14 recommended non-certification.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar epidural steroid injection: 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 Injections (ESIs) Page(s): 46.

Decision rationale: Report from 3/3/14 specifies more details to support epidural steroid injection request. Level to be injected is L4-5. There is no mention if it will be done under fluoroscopy. Last ESI performed in 2010 provided 50% benefit for more than 6months. Another ESI on 8/16/11 worsened pain. As per MTUS Chronic Pain Guidelines, Epidural Steroid Injection(ESI) has some utility in reducing pain to facilitate more active treatment and avoiding surgery but little other benefit is noted beyond those 2 benefits. Patient must meet specific guidelines before ESI can be recommended.1)Radiculopathy has been documented on exam, corroborated by imaging and EMG studies in the past. Meets criteria.2)Patient is not responsive to current therapy including, physical exercise, pain medications and Gabapentin although there is no documentation if any other anti-epileptic therapy. Meets criteria.3)Injections should be performed under fluoroscopic guidance. Does not meet criteria. There is no mention of technique of ESI to be attempted.4)No more than 2 nerve roots to be injected. Meets criteria.5)No more than 1 inter laminar level to be injected. Meets criteria.6)Patient has a reported 50% improvement in pain lasting 6months in prior ESI done in 2010 but ESI done on 8/16/11 actually worsened pain. Does not meet criteria. In conclusion, patient does not meet criteria for recommendation of ESI. Patient had reported worsening of pain during prior attempt at ESI with report by treating physician noting "poor flow of contrast via caudal approach suggestive of increased fibrosis in sacral canal". While it may be assumed that ESI would likely be performed using fluoroscopy, since the prior ESIs were done using that technique, the treating physician did not specifically state if it would be done using fluoroscopy. The provided documentation does not meet the MTUS Chronic Pain Guidelines criteria for Epidural Steroid Injection. Therefore ESI is not medically necessary.