

Case Number:	CM14-0038473		
Date Assigned:	06/27/2014	Date of Injury:	09/12/2011
Decision Date:	08/15/2014	UR Denial Date:	03/14/2014
Priority:	Standard	Application Received:	04/01/2014

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 Occupational 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:

This is a 32-year-old male patient with a 9/12/11 date of injury. He injured himself while loading chairs into the truck. An orthopedic consultation note dates on 4/23/14 indicated that the patient had persistent pain in his lower back and right leg. Physical exam demonstrated mild weakness throughout the bilateral lower extremities, which was not neurologic weakness. X-ray dated on 4/23/14 showed trace retrolisthesis on L5-S1 and mild disc space narrowing at L5-S1. MRI dated on 2/24/14 revealed stable L5-S1 right paracentral and lateral disc protrusion causing moderate right lateral canal and right lateral recess stenosis deflecting the right S1 nerve root sleeve unchanged since prior study. She was diagnosed with Chronic low back pain and right leg pain and L5-S1 disc protrusion with slight deflection of the traversing S1 nerve root. Treatment to date: medication management and epidural steroid injection. There is documentation of previous 3/14/14 adverse determination, based on the fact that there was no documentation of radiculopathy and loss of sensation the epidural steroid injection was not certified. Sacroiliac joint injection was not certified, because there was indication that the patient had other possible pain generators.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Right Transforaminal Epidural Steroid Injection S1 level: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines (Epidural Steroid Injection) Page(s): 46.

Decision rationale: CA MTUS does not support epidural injections in the absence of objective radiculopathy. In addition, CA MTUS criteria for the use of epidural steroid injections include an imaging study documenting correlating concordant nerve root pathology; and conservative treatment. Furthermore, repeat blocks should only be offered if there is at least 50-70% pain relief for six to eight weeks following previous injection, with a general recommendation of no more than 4 blocks per region per year. The patient presented with pain in his lower back and the right leg. There was documentation that the patient had a prior epidural steroid injection. However, there was no documentation of pain relief or duration of positive response of treatment. In addition, guidelines only support repeat epidural steroid injection if there is at least 50-70% pain relief for six to eight weeks following previous injection. Therefore, the request for 1 Right Transforaminal Epidural Steroid Injection S1 level was not medically necessary.

1 Right Sacroiliac Joint Injection: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation OFFICIAL DISABILITY GUIDELINES - Hip & Pelvis (Acute & Chronic).

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) (Hip and Pelvis Chapter, Sacroiliac joint injections).

Decision rationale: CA MTUS states that sacroiliac joint injections are of questionable merit. In addition, ODG criteria for SI joint injections include clinical sacroiliac joint dysfunction, failure of at least 4-6 weeks of aggressive conservative therapy, and the history and physical should suggest the diagnosis (with documentation of at least 3 positive exam findings). The patient presented with pain in his lower back and the right leg. However, there was no documentation of failure of aggressive conservative treatment for at least 4-6 weeks. In addition, there was no evidence of at least 3 positive exam findings suggesting the diagnosis. Therefore, the request for 1 Right Sacroiliac Joint Injection was not medically necessary.