

Case Number:	CM14-0051988		
Date Assigned:	06/23/2014	Date of Injury:	07/09/2010
Decision Date:	07/25/2014	UR Denial Date:	03/10/2014
Priority:	Standard	Application Received:	03/21/2014

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, has a subspecialty in Interventional Spine 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:

The patient is a 37 year old male with an injury date of 07/09/10. Based on the 03/03/14 progress report provided by [REDACTED], the patient complains of achy lower back pain, with stinging, burning, throbbing pain shooting down to the bilateral lower extremities in the L5 dermatomes to the ankle. He has tenderness in the lateral aspect of his left foot. The 03/03/14 report states Neuro-circulatory status is intact. TTP b/l paraspinal muscles, TTP lower lumbar disc spaces. ROM lim in flexion, extension due to LBP. MMT 4/5 bilateral ankle DF, EHL. Reflexes 2+ and symm. Sensation to LT reduced in the dorsal aspects of both feet. His diagnoses include the following: Lumbar degenerative, Lumbar disc pathology, Lumbar degenerative disk disease and Lumbar radiculopathy. The 08/22/10 MRI of the lumbar spine revealed L4-5, 2-3 mm broad based and lateral subligamentous protrusion, L5-S1, compatible with disk degeneration. Moderate hypertrophic facet arthropathy 2-3 mm broad based central oriented subligamentous protrusion with mild thecal sac effacement, and potential for bilateral L5 nerve impingement. [REDACTED] is requesting for one lumbar transforaminal caudal epidural steroid injection with fluoroscopic guidance. The utilization review determination being challenged is dated 03/10/14. [REDACTED] is the requesting provider, and he provided three treatment reports from 01/08/14, 03/03/14, and 03/17/14.

IMR ISSUES, DECISIONS AND RATIONALES

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

One lumbar transforaminal caudal epidural steroid injection with fluoroscopic guidance:
Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines "Epidural steroid injections (ESIs) Page(s): 46.

Decision rationale: According to the 03/03/14 report by [REDACTED], the patient presents with an achy lower back pain, with stinging, burning, throbbing pain shooting down to the bilateral lower extremities in the L5 dermatomes to the ankle. The request is for one lumbar transforaminal caudal epidural steroid injection with fluoroscopic guidance. The 03/03/14 report states that the patient had A previously provided fluoro-guided caudal ESI gave him 70% improvement of his LBP that lasted for 12 weeks. He is agreeable to have a repeat injection performed. No need for pain med refills at this time. The date of this ESI was not mentioned in any of the reports or in the utilization review letter. The California MTUS guidelines requires 50% reduction of pain lasting 6 weeks or more with reduction in medication use for repeat injection. In this case, the provider indicates that the patient's prior injection resulted in 70% improvement lasting 12 weeks. Reports are not available to verify this information and to determine whether or not significant functional improvement with medication reduction were achieved. The patient does appear to present with dermatomal distribution of right leg pain but examination does not support a diagnosis of L5 radiculopathy. There is no mention of SLR, and motor/sensory examination do not show L5 nerve root problem. Furthermore, MRI's findings only show 2-3 mm disc at L5-S1 centrally without description of foraminal stenosis that would explain the patient's potential L5 nerve root problem. There were no HNP or central stenosis at L4-5 that would result in L5 nerve root problems. Given the paucity of exam findings and an MRI that does not support L5 nerve root lesion, the request is not medically necessary.