

Case Number:	CM14-0053636		
Date Assigned:	07/07/2014	Date of Injury:	07/05/2005
Decision Date:	08/29/2014	UR Denial Date:	03/28/2014
Priority:	Standard	Application Received:	04/22/2014

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:

The patient is a 52-year-old male who has submitted a claim for Radiculitis of the Right Lower Extremity, Low Back Pain, Herniated Discs, and Annular Tear associated with an industrial injury date of July 7, 2005. Medical records from 2013 through 2014 were reviewed, which showed that the patient complained of low back pain. On physical examination, gait was within normal limits. Tenderness was noted in the parathoracic and paralumbar musculature. No tenderness was noted in the posterior superior iliac spine region and sacroiliac joints. Muscle spasm was found in the paralumbar musculature. No motor deficits were noted in the lower extremities. Walking on tiptoes and on heels was performed without difficulty. Deep tendon reflexes were normal. There was limitation in lumbar spine range of motion. Straight leg raise test was positive on the right. Diminished sensation was also noted but the location was not specified. Numbness was reported at the lateral aspect of the left thigh. Treatment to date has included medications, physical therapy, and acupuncture. Utilization review from March 28, 2014 denied the request for Lumbar Epidural Injection because the records did not document symptoms, exam findings, and diagnostic data, which corroborate the presence of a radiculopathy at a particular focal level.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar Epidural Injection: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 52.

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

Decision rationale: According to page 46 of the CA MTUS Chronic Pain Medical Treatment Guidelines, criteria for the use of epidural steroid injections include: (1) radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing; (2) initially unresponsive to conservative treatment; (3) no more than two nerve root levels should be injected using transforaminal blocks; and (4) no more than one interlaminar level should be injected at one session. In this case, the records stated that the patient was unresponsive to prior conservative management and there was documentation of examination findings of radiculopathy. However, the records did not include imaging or electrodiagnostic studies to corroborate these examination findings. Furthermore, the present written request failed to specify the lumbar levels to be injected. The request is incomplete. Therefore, the request for Lumbar Epidural Injection is not medically necessary.