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| Case Number: | CM14-0055134 | | |
| Date Assigned: | 07/09/2014 | Date of Injury: | 05/18/2010 |
| Decision Date: | 08/18/2014 | UR Denial Date: | 04/18/2014 |
| Priority: | Standard | Application Received: | 04/24/2014 |

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 & Rehabilitation, has a subspecialty in Pain Medicine and is licensed to practice in Texas and Oklahoma. 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 injured worker is a 51-year-old male who reported injury on 05/18/2010, caused by unspecified mechanism. The injured worker's treatment history included medications, physical therapy treatment, NCV/EMG, and MRI studies. It was noted within the documentation that the injured worker had undergone an EMG/NCV of the right lower extremity on 01/31/2014 that concluded mild right S1 radiculopathy, based on prolonged right H-reflex latency. There were no active denervation potentials. On 11/25/2013, the injured worker had undergone an MRI study of the lumbar spine that revealed at L3-4 there was disc desiccation without narrowing seen; a 3 mm diffuse disc bulge was noted; the bulging encroaches upon the ventral aspect of the thecal sac at this site. There was extensive degenerative bone, disc, and joint changes seen throughout the majority of the lumbar spine with associated spinal stenosis and bilateral foraminal narrowing. Prior MRI of the lumbar spine dated 03/08/2011, there was no significant interval change. The injured worker was evaluated on 04/15/2014, and it was documented that the injured worker complained of low back pain and constant leg pain. The physical examination of the lumbar spine had positive bilateral paralumbar tenderness to palpation. The straight leg raise was pain on the right at 85 degrees and on the left at 80 degrees. The lower extremity motor strength was 5/5. The sensation was intact. The straight leg raise was pain on the right at 85 degrees and 80 degrees on the left. The range of motion was 5 degrees, 20 degrees, 30 degrees and 20 degrees with pain. Within the notes, it was documented that the injured worker had undergone a lumbar spine epidural steroid injection on 12/17/2013 with noted slight improvement. Medications included Vicodin and Gabapentin. Diagnoses included right S1 radiculopathy, stenosis at L3-4. The request for authorization dated on 03/14/2014 was for an L3-4 lumbar epidural injection; however, the rationale was not submitted for this review.

IMR ISSUES, DECISIONS AND RATIONALES

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

L3-4 Lumbar Epidural: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection (ESIs) Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines EPIDURAL STEROID INJECTIONS (ESIS) Page(s): 46.

Decision rationale: The requested service is not medically necessary. The California Treatment Guidelines recommend epidural steroid injections as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electro diagnostic testing. Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). The provider noted the injured worker had undergone a previous epidural steroid injection with slight improvement; however, there was lack of documentation of home exercise regimen and physical therapy sessions indicating long-term functional improvement goals. The documents provided indicated the injured worker had undergone an NCV/EMG study on 01/31/2014 revealed electrodiagnostic evidence of a mid-right S1 radiculopathy, based on a prolonged right H reflex latency. There was no active denervation. The documents submitted on 04/15/2014 included diagnoses of right S1 radiculopathy and L3-4 stenosis. Given the above, the request for L3-4 epidural steroid injection is not medically necessary.