

Case Number:	CM14-0056667		
Date Assigned:	07/09/2014	Date of Injury:	11/11/2013
Decision Date:	10/09/2014	UR Denial Date:	04/01/2014
Priority:	Standard	Application Received:	04/28/2014

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 and 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 43-year-old male who reported an injury on 11/11/2013. The mechanism of injury was a motor vehicle accident. On 02/10/2014, the injured worker presented with low back and right and left leg pain. Upon examination, there was tenderness to palpation to the low back area. There was significant restricted range of motion of the lumbar spine due to pain. There were 1+ reflexes in the ankles and sensation grossly intact. There was 4/5 strength bilaterally of the tibialis anterior and EHL, partly due to pain. There was a positive bilateral straight leg raise. An MRI of the lumbar spine dated 11/27/2013 revealed L4-5 moderate broad based disc bulge with broad based 9 mm by 5 mm right paracentral protrusion smaller than on the prior exam which resulted in effacement of the anterior thecal sac and likely abutment of the right L5 nerve root in the left lateral recess. Mild relative central canal stenosis is present and improved from the prior exam with facet/ligament hypertrophy resulting in grossly stable moderate bilateral neural foraminal narrowing. Diagnoses were chronic intervertebral back pain, facet arthropathy at L3-4, L4-5 central herniation and transitional segment anomaly. Prior therapy included injections, the use of ice, and medications. The provider recommended a lumbar ESI (epidural steroid injection) under fluoroscopy at L4-5 levels. The provider's rationale was not provided. The Request for Authorization form was not included in the medical documents for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar Epidural Steroid Injection under fluoroscopy at L4-L5: Upheld

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

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

Decision rationale: The request for lumbar epidural steroid injection under fluoroscopy at L4-L5 is not medically necessary. According to California MTUS Guidelines, an epidural steroid injection may be recommended to facilitate progress in more active treatment programs when there is radiculopathy documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Additionally, the documentation should show the injured worker was initially unresponsive to conservative treatment. Injections should be performed with the use of fluoroscopy for guidance and no more than 2 root levels should be injected using transforaminal blocks. The documentation submitted for review stated the injured worker completed initially recommended conservative treatment. An MRI was noted to have pathology at L4-5 levels resulting in grossly stable moderate bilateral neural foraminal narrowing. Physical examination revealed positive bilateral straight leg raise, tenderness to palpation in the lower back, and 4/5 strength bilaterally at the tibials anterior and EHL. The physical examination findings do not clearly corroborate radiculopathy. In addition, the documentation failed to show the injured worker would be participating in a active treatment program following the requested injection. In summary, despite documentation showing persistent radiating symptoms, and despite conservative treatment, in the absence in the clear corroboration of radiculopathy by physical exam findings and imaging study and/or electrodiagnostic test results, and documentation showing a plan for active therapy following the injection, the request is not supported. Based on all of the above, the request is not medically necessary.