

Case Number:	CM14-0058502		
Date Assigned:	07/11/2014	Date of Injury:	03/12/2001
Decision Date:	08/22/2014	UR Denial Date:	04/08/2014
Priority:	Standard	Application Received:	04/29/2014

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 Anesthesiology, has a subspecialty in Pain Management 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:

According to the records made available for review, this is a 52-year-old male with a 3/12/01 date of injury. At the time (3/17/14) of request for authorization for left hip injection and bilateral L5 transforaminal epidural Injection, there is documentation of subjective lumbar pain, aching nerve pain, radicular nerve pain constant with pain that radiates into left leg. Objective findings were lumbar spine range of motion: flexion 45 degrees, extension 10 degrees, 15 degrees of lateral flexion bilaterally, and 10 degrees of rotation bilaterally, pain with lumbar spine range of motion test, negative straight leg raising, positive Patrick test and reverse Thomas test bilaterally, absent knee and ankle reflexes bilaterally, normal sensation in bilateral lower extremities, 5/5 motor strength bilaterally in lower extremities, tenderness to palpation over the lumbar facet joints, no tenderness to palpation over sacroiliac joints. Imaging findings reported lumbar spine MRI (undated) revealed an injured disc; report not available for review. Current diagnoses include degenerative lumbar disc, lumbar spondylosis without myelopathy, lumbar radiculopathy, peripheral neuropathy, unspecified, and trochanteric bursitis. Treatment to date is home exercise program, physical therapy, activity modifications, and medications (including MS Contin and Ultram). Regarding left hip injection, there is no documentation of subjective or objective findings consistent with trochanteric bursitis. Regarding bilateral L5 transforaminal epidural injection, there is no documentation of subjective and objective radicular findings in the requested nerve root distribution, and imaging findings at the requested level.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral L5 Transforaminal epidural Injection: 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. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back, Epidural Steroid Injections (ESIs).

Decision rationale: MTUS reference to ACOEM guidelines identifies documentations of objective radiculopathy in an effort to avoid surgery as criteria necessary to support the medical necessity of epidural steroid injections. The Official Disability Guidelines (ODG) identifies documentation of subjective (pain, numbness, or tingling in a correlating nerve root distribution) and objective (sensory changes, motor changes, or reflex changes (if reflex relevant to the associated level) in a correlating nerve root distribution) radicular findings in each of the requested nerve root distributions, imaging (MRI, CT, myelography, or CT myelography & x-ray) findings (nerve root compression OR moderate or greater central canal stenosis, lateral recess stenosis, or neural foraminal stenosis) at each of the requested levels, failure of conservative treatment (activity modification, medications, and physical modalities), and no more than two nerve root levels injected one session; as criteria necessary to support the medical necessity of lumbar epidural steroid injection. Within the medical information available for review, there is documentation of diagnoses of degenerative lumbar disc, lumbar spondylosis without myelopathy, lumbar radiculopathy, peripheral neuropathy, unspecified, and trochanteric bursitis. In addition, there is documentation of failure of conservative treatment (activity modification, medications, and physical modalities) and no more than two nerve root levels injected one session. However, despite nonspecific documentation of subjective (lumbar pain, aching nerve pain, radicular nerve pain constant with pain that radiates into left leg) findings, there is no specific (to a nerve root distribution) documentation of subjective (pain, numbness, or tingling) radicular findings in the requested nerve root distribution. In addition, given documentation of objective (normal sensation in bilateral lower extremities and 5/5 motor strength bilaterally in lower extremities) findings, there is no documentation of objective (sensory changes, motor changes, or reflex changes) radicular findings in the requested nerve root distribution. Furthermore, despite documentation of the 6/17/13 medical report's reported imaging findings (Lumbar Spine MRI identifying an injured disc), there is no documentation of imaging (MRI) findings (nerve root compression OR moderate or greater central canal stenosis, lateral recess stenosis, or neural foraminal stenosis) at the requested level. Therefore, based on guidelines and a review of the evidence, the request for bilateral L5 transforaminal epidural Injection is not medically necessary.

Left Hip 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 (ODG), Hip & Pelvis (Acute & Chronic).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Hip and Pelvis, Trochanteric Bursitis Injections.

Decision rationale: MTUS does not address this issue. The Official Disability Guidelines (ODG) supports a trochanteric corticosteroid injection as a first-line treatment of trochanteric bursitis. Within the medical information available for review, there is documentation of diagnoses of degenerative lumbar disc, lumbar spondylosis without myelopathy, lumbar radiculopathy, peripheral neuropathy, unspecified, and trochanteric bursitis. However, despite documentation of trochanteric bursitis, there is no documentation of subjective or objective findings consistent with trochanteric bursitis. Therefore, based on guidelines and a review of the evidence, the request for left greater trochanteric bursal injection is not medically necessary.