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| Case Number: | CM14-0070468 | | |
| Date Assigned: | 07/14/2014 | Date of Injury: | 11/21/1999 |
| Decision Date: | 09/12/2014 | UR Denial Date: | 04/28/2014 |
| Priority: | Standard | Application Received: | 05/15/2014 |

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 Tennessee. 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:

This is a 63-year-old male with a 11/21/99 date of injury. The mechanism of injury was not noted. According to a 4/16/14 orthopaedic consultation report, the patient stated that his symptoms have gotten progressively worse in the last three months. He has difficulty walking and has pain in his back with sitting. He gets numbness and tingling into his leg and can't sit down. The pain in his back and legs was rated a 6/10. Objective findings: discomfort in lumbosacral area, restricted ROM of lumbar spine, sensation intact to light touch, proprioception and sharp/dull bilaterally; motor examination 5/5 in lower extremities; severe discoloration and mild swelling in left leg. An MRI report dated 3/12/14 revealed: 1) compared to prior report of MRI from 2007, internal increase in degenerative spondylosis. Hyperintense Schmorl's node in the inferior endplate of L1 is probably an interval change. 2) Compared to prior study increase in lumbar spinal canal stenosis with high-grade central stenosis with lateral recess stenosis at L4-5 with facet arthropathy ligamentum flavum hypertrophy. Associated disc osteophyte complex with foraminal compromise with left lateral disc osteophyte complex contacting the left L4 nerve root. 3) Interval change of mild to moderate central spinal canal stenosis at L3-4 with facet arthropathy, ligamentum flavum hypertrophy and small disc osteophyte complex. 4) Disc osteophyte complex at L5-S1 is smaller, no central stenosis, bilateral facet arthropathy. 5) small disc osteophyte complex at L2-3 is again noted with borderline central spinal canal stenosis. 6) Multilevel 2 mm disc osteophyte complexes in the lower thoracic region and L1-L2. Diagnostic impression: spinal stenosis, neurogenic claudication. Treatment to date: medication management, activity modification, physical therapy, bilateral total knee replacement, A UR decision dated 4/28/14 denied the request for bilateral lumbar ESI at L4-L5. There is insufficient documentation of motor or sensory deficits in the L4 nerve root distribution to support the need for a lumbar ESI. In fact, the claimant's motor and sensory testing is intact.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral lumbar epidural steroid injection at L4-L5: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300. Decision based on Non-MTUS Citation Other Medical Treatment Guideline or Medical Evidence: AMA Guides (Radiculopathy).

Decision rationale: CA MTUS does not support epidural injections in the absence of objective radiculopathy. In addition, CA MTUS criteria for the use of epidural steroid injections include an imaging study documenting correlating concordant nerve root pathology; and conservative treatment. Furthermore, repeat blocks should only be offered if there is at least 50-70% pain relief for six to eight weeks following previous injection, with a general recommendation of no more than 4 blocks per region per year. The patient is documented to have a normal neurological examination on physical exam. There is no documentation of failure to recent conservative management. In addition, this patient has a 1999 date of injury, and it is unclear whether he has had prior ESIs in the 15 years since his date of injury, and if he did, whether he had functional gains or improvements from the ESIs. Therefore, the request for Bilateral lumbar epidural steroid injection at L4-L5 was not medically necessary.