

Case Number:	CM14-0196625		
Date Assigned:	12/04/2014	Date of Injury:	06/10/2013
Decision Date:	01/23/2015	UR Denial Date:	11/12/2014
Priority:	Standard	Application Received:	11/24/2014

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 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:

This 45 year old woman sustained an industrial injury on 6/10/2013 resulting in injuries to the left shoulder, thoracic, and lumbar spine. Evaluations included x-rays of the left shoulder, thoracic and lumbar spine on 7/31/2013, MRI of the left shoulder 8/16/2013 showed full thickness tear of the supraspinatus tendon without retraction, mild tendonitis of infraspinatus tendon and a tear of the labrum, MRI of the lumbar spine without contrast on 10/17/2014 showed partial disc desiccation with a 1mm disc bulge at L3-L4, partial disc desiccation with a 2mm posterior bulge at L4-L5, mild narrowing of the thecal sac, mild facet hypertrophy, 1-2mm posterior disc bulge at L5-S1 and mild narrowing of the thecal sac. Treatment included physical therapy, activity modification, left shoulder arthroscopy on 3/15/2014, cortisone injection to the left shoulder, and oral medications. The worker was currently following a home exercise program. Physician notes included on the PR-2 dated 12/27/2014, state that the worker is experiencing significant lumbar pain with radicular symptoms as well as left shoulder and spine pain. Lumbar spine range of motion is limited and gross motor weakness is noted. These symptoms are increased when related to physician notes on a PR-2 from 9/29/2014, which states that she has been having low back pain since a flare up in July of 2014. It is described as constant and radiates down the left leg and causes numbness and tingling with limited range of motion. On 11/12/2014, Utilization Review evaluated a prescription for a lumbar epidural steroid injection at L4-L5. The UR physician noted that there was no documented indication of radiculopathy. The request was denied and subsequently appealed to Independent Medical Review.

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, L4-L5: 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 ACOEM Chapter 12 Low Back Complaints Page(s): 288, 309-310, Chronic Pain Treatment Guidelines Part 2 Page(s): 39-40, 46.

Decision rationale: The best medical evidence today for individuals with low back pain indicates that having the patient return to normal activities provides the best outcomes. Therapy should be guided, therefore, with modalities which will allow this outcome. Epidural steroid injections are an optional treatment for pain caused by nerve root inflammation as defined by pain in a specific dermatome pattern consistent with physical findings attributed to the same nerve root. As per the MTUS the present recommendations is for no more than 2 such injections, the second being done only if there is at least a partial response from the first injection. Its effects usually will offer the patient short term relief of symptoms as they do not usually provide relief past 3 months, so other treatment modalities are required to rehabilitate the patient's functional capacity. The MTUS provides very specific criteria for use of this therapy. Specifically, the presence of a radiculopathy documented by examination and corroborated by imaging, and evidence that the patient is unresponsive to conservative treatment. In the documented care for this patient these criteria are not met. Even though the history is compatible with a possible radiculopathy, this is not supported by the exam, which is non-specific for a radiculopathy. Additionally, the degenerative changes in the lumbar spine noted on the lumbar MRI are non-specific and do not describe nerve impingement. Thus, the patient does not meet the criteria for this requested therapy. Therefore the request is not medically necessary.