

Case Number:	CM15-0181856		
Date Assigned:	09/23/2015	Date of Injury:	05/13/2009
Decision Date:	10/27/2015	UR Denial Date:	09/11/2015
Priority:	Standard	Application Received:	09/15/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:

State(s) of Licensure: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 55 year old female, who sustained an industrial injury on 05-13-2009. The injured worker is currently permanent and stationary. Medical records indicated that the injured worker is undergoing treatment for lumbar radiculopathy, failed lumbar back syndrome, sacroiliac joint pain, myofascial pain syndrome, cervical degenerative disc disease, and cervical spondylosis. Treatment and diagnostics to date has included injections and medications. Current medications include Hydrocodone-Acetaminophen, OxyContin, and Trazodone. No MRI reports noted in received medical records. In a progress note dated 09-02-2015, the injured worker reported pain in neck, shoulders, lower back, and right lower extremity. The treating physician noted that the injured worker rated her worst pain at 9 out of 10 with an average of 7 out of 10, that "patient function improves 75% with medication", and the patient underwent sacroiliac joint injections on 08-18-2015 with at least "50-60% improvement in her low back pain". Objective findings included antalgic gait, lumbar paravertebral spasm and tenderness with restricted range of motion, and positive right sided straight leg raise test. The Utilization Review with a decision date of 09-10-2015 non-certified the request for lumbar spine x-ray and lumbar transforaminal epidural steroid injection at right L5-S1 and S1.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar TF ESI at right L5-S1 and S1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

Decision rationale: The claimant sustained a work injury in May 2009 and has a history of a multilevel lumbar fusion. When seen, she was having neck, shoulder, and low back pain with lower extremity symptoms. She had undergone bilateral sacroiliac joint injections on 08/18/15 with improvement and was working and exercising. She was having increased right lower extremity radicular pain rated at 7-9/10. Physical examination findings included a body mass index of 34. There was an antalgic gait. There was lumbar paravertebral tenderness with spasms and bilateral sacroiliac joint tenderness. Straight leg raising was positive. There was a normal neurological examination. Authorization for an epidural injection and for x-rays of the lumbar spine including flexion/extension views to evaluate the claimant's fusion was requested. Criteria for the use of epidural steroid injections include radicular pain, defined as pain in dermatomal distribution with findings of radiculopathy documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. In this case, there are no physical examination findings such as decreased strength or sensation in a myotomal or dermatomal pattern or asymmetric reflex response that support a diagnosis of radiculopathy. The requested epidural steroid injection is not considered medically necessary.

X-ray of the lumbar spine: Overturned

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back-Lumbar & Thoracic (Acute & Chronic), Radiography (x-rays).

Decision rationale: The claimant sustained a work injury in May 2009 and has a history of a multilevel lumbar fusion. When seen, she was having neck, shoulder, and low back pain with lower extremity symptoms. She had undergone bilateral sacroiliac joint injections on 08/18/15 with improvement and was working and exercising. She was having increased right lower extremity radicular pain rated at 7-9/10. Physical examination findings included a body mass index of 34. There was an antalgic gait. There was lumbar paravertebral tenderness with spasms and bilateral sacroiliac joint tenderness. Straight leg raising was positive. There was a normal neurological examination. Authorization for an epidural injection and for x-rays of the lumbar spine including flexion/extension views to evaluate the claimant's fusion was requested. An x-ray of the lumbar spine can be recommended after surgery to evaluate the status of a fusion. In this case, the claimant has low back pain with decreased and painful range of motion with a history of a multilevel fusion to the sacrum and is having increased right lower extremity radicular pain. The requested x-rays are medically necessary.

