MAXIMUS Federal Services

Case Number:	CM15-0020585		
Date Assigned:	02/10/2015	Date of Injury:	06/14/2014
Decision Date:	04/03/2015	UR Denial Date:	01/30/2015
Priority:	Standard	Application Received:	02/04/2015

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: California
Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 44-year-old male who reported an injury on 06/14/2014. There was a Request for Authorization submitted for review dated 01/26/2015. The mechanism of injury was the injured worker was mopping floors when he slipped on a wet floor, landing on his back, and injured his cervical spine, back, shoulders, arms, hands, and bilateral knees. The MRI of the lumbar spine on 08/29/2014 revealed at the level of L4-5, there was no significant disc herniation. There were peridiscal osteophytes on the bilateral sides with hypertrophy of the facet joints and ligamentum flavum causing spinal canal narrowing and neural foraminal narrowing bilaterally. At L5-S1, there was a diffuse disc protrusion without effacement of the thecal sac. The spinal canal was normal in configuration and showed no sign of stenosis. There was hypertrophy at the facet joint and ligamentum flavum noted. There was no effacement of the transiting nerve roots. The disc material and facet hypertrophy caused bilateral neural foraminal narrowing effacing the left and right L5 exiting nerve roots. The treatment plan included therapy to the bilateral shoulders, elbows, knees, hands, and wrists, and a lumbar epidural steroid injection as well as an EMG/NCV of the bilateral upper extremities. The documentation of 01/14/2015 revealed the injured worker had MRIs, shock wave therapy, physical therapy, and acupuncture. The current complaints revealed the injured worker had constant pain in the low back. The pain traveled to his legs causing numbness and tingling sensation extending to his buttocks. The pain increased with sitting, standing, walking, and pulling. Prior surgeries were stated to be none. The medications were noted to include APAP with codeine, omeprazole, cyclobenzaprine, and topical creams. Physical examination of the lumbar spine revealed

decreased range of motion. The injured worker had a positive Lasegue's on the left and it was equivocal on the right. There was a positive straight leg raise at 70 degrees on the left and cross leg raise was positive at 80 degrees on the right, eliciting pain in the L5-S1 dermatomal distribution. The reflexes were 1+ bilaterally in the knees and absent bilaterally in the ankles. Additionally, there was tenderness to palpation in the posterosuperior spine. There was hypoesthesia at the anterolateral aspect of the foot and ankle of an incomplete nature noted at the L5 and S1 dermatome levels bilaterally. There was knee in the big toe dorsiflexor and the big toe plantar flexor. The injured worker had facet joint tenderness at the L5 level on the right. The strength was 4/5 in the foot dorsiflexor and foot evertor on the left. The diagnoses included lumbar radiculitis and radiculopathy, left greater than right, secondary to herniated lumbar disc, positive MRI. The treatment plan included a lumbar epidural steroid injection at L4-5 and L5-S1 with epidurogram.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar epidural based steroid therapeutic pain management at the level of L4-L5, L5-S1 with Epidurogram: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs).

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

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend epidural steroid injections when there is documentation of objective findings of radiculopathy upon physical examination that are corroborated with imaging studies. There should be documentation of a failure of conservative care including exercises, physical methods, NSAIDs, and muscle relaxants. The injections should be provided under fluoroscopy. The clinical documentation submitted for review indicated the injured worker had objective findings at L4-5 and L5-S1 upon physical examination. However, there was a lack of documentation of corroboration of both levels per MRI study. The documentation indicated the injured worker had objective findings of nerve impingement at L5-S1. This request would not be supported. Given the above, the request for lumbar epidural steroid injection with therapeutic plan management at the level of L4-5, L5-S1 with epidurogram is not medically necessary.