

Case Number:	CM15-0045578		
Date Assigned:	03/17/2015	Date of Injury:	03/17/2004
Decision Date:	04/14/2015	UR Denial Date:	02/27/2015
Priority:	Standard	Application Received:	03/10/2015

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 claimant is more than 11 years status post work-related injury and continues to be treated for chronic back pain. When seen by the requesting provider on 02/05/15 he had right sided low back pain. Physical examination findings included decreased and painful lumbar spine range of motion with positive facet loading. There was a positive right straight leg raise with normal strength and sensation. Gait was slightly antalgic. A series of two lumbar transforaminal epidural steroid injections was requested. An MRI of the lumbar spine on 03/17/15 included findings of moderate right lateralized disc extrusion at L2/3 and multilevel degenerative disc disease with mild to moderate right foraminal narrowing.

IMR ISSUES, DECISIONS AND RATIONALES

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

Transforaminal Lumbar Epidural Steroid Injection Right L4-L5: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Criteria for the use of Epidural steroid injections Page(s): 46.

Decision rationale: Criteria for the use of epidural steroid injections include that radiculopathy be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. In this case, the claimant's provider documents positive neural tension signs and imaging has shown findings consistent with the presence of radiculitis. The claimant has radicular symptoms and an antalgic gait. Guidelines recommend up to 2 injections in the diagnostic phase. The request meets the applicable criteria and is therefore medically necessary. Criteria for the use of Epidural steroid injections, p46.