

Case Number:	CM14-0110331		
Date Assigned:	08/01/2014	Date of Injury:	10/03/2012
Decision Date:	10/17/2014	UR Denial Date:	06/17/2014
Priority:	Standard	Application Received:	07/15/2014

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 37 year old male with a 10/3/2012 date of injury. The exact mechanism of the original injury was not clearly described. A progress reported dated 5/28/14 noted subjective complaints of low back pain radiating to the legs. Objective findings included lumbosacral muscle spasms and tenderness. Straight leg raise was positive on the left side. It was noted that the request for lumbar ESI is due to 4-mm disc bulgae at L5 level and he showed radiculopathy more on the left side. Lumbar MRI 11/14/12 showed no evidence of central canal or neural foraminal narrowing at any level. No evidence of neural impingement. Diagnostic Impression: lumbar strain. Treatment to Date: diagnostic facet block, physical therapy, medication management. A UR decision dated 6/17/14 denied the request for left L5 transforaminal epidural steroid injection under fluoroscopic guidance. Based on the clinical information and using evidence based, peer-reviewed guidelines, this request is not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left L5 Transforaminal Epidural Steroid Injection under Fluoroscopic Guidance: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): Page 46.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines epidural steroid injections Page(s): 46.

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. However, there is no MRI evidence of neural impingement to corroborate the clinical diagnosis of radiculopathy. There is no documentation of failure of conservative management such as physical therapy. Therefore, the request for transforaminal epidural steroid injection under fluoroscopic guidance is not medically necessary.