

Case Number:	CM14-0124042		
Date Assigned:	08/08/2014	Date of Injury:	02/08/2000
Decision Date:	10/09/2014	UR Denial Date:	07/25/2014
Priority:	Standard	Application Received:	08/05/2014

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 Family Practice and is licensed to practice in Texas, Mississippi. 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:

The injured worker is a 63 year-old male who reported a work related injury on 02/08/2000 due to lifting a glass door and reinstalling it and injuring his neck, back, and shoulders. The injured workers diagnoses consisted of lumbar disc degeneration, spinal stenosis, and sciatica. The injured worker was previously treated with multiple sessions of physical therapy which did not yield any pain relief, medications, and epidural steroid injections. The most recent epidural steroid injection occurred on 03/15/2014. The injured worker stated the injection helped considerably for a few weeks and has worn off some but is still effect and provided 85 percent pain relief for 4 months. A MRI dated 07/26/2012 revealed bilateral facet arthropathy at L3-S1 with bilateral moderate neural foraminal stenosis at L4-5. Upon examination on 07/17/2014 the injured worker stated he cannot stand or sit for longer than 15 minutes and had difficulty walking more than a block. The injured worker had a positive straight leg raise bilaterally and experienced difficulty going from the sitting to standing position. The injured worker's prescribed medications consist of Hydrocodone, Ambien, Celebrex, Gabapentin, and Norco. The treatment plan stated the injured worker has failed conservative management and continued to experience pain. The plan consisted of epidural steroid injections under fluoroscopy and moderate sedation and a medication regime. The rationale for the request is pain relief. The request for authorization form was submitted for review on 07/18/2014.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral L4-5 epidural injection: Upheld

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

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

Decision rationale: According to the California MTUS Guidelines, repeat epidural steroid injections should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks after previous injection. Within the documentation provided, upon physical examination there were no signs to coincide with radiculopathy such as sensory changes or motor strength deficits in a specific dermatomal or myotomal distribution. Documentation does reveal that the injured worker received 85 percent pain relief for 4 months. However, the amount of functional improvements and decreased medication use with prior epidural steroid injections was not clearly specified. As such, the request for Bilateral L4-5 epidural steroid injection is not medically necessary.