

Case Number:	CM14-0151182		
Date Assigned:	09/26/2014	Date of Injury:	11/15/2011
Decision Date:	10/27/2014	UR Denial Date:	08/27/2014
Priority:	Standard	Application Received:	09/16/2014

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 Occupational Medicine and is licensed to practice in California. 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:

Injured worker is a male with date of injury 11/15/2011. Per pain medicine re-evaluation dated 8/18/2014, the injured worker complains of neck and low back pain. The neck pain radiates down bilateral upper extremities and is aggravated by activity and walking. The low back pain radiates down bilateral lower extremities and is accompanied by numbness to the level of the toes. Pain is aggravated by activity, prolonged sitting, standing and walking. He complains of frequent muscle spasms in the low back. Pain is rated at 10/10 with medications and without medications. His pain is reported as unchanged since his last visit. On examination the injured worker was observed to be in moderate distress. His gait was slow. Cervical spine vertebral tenderness was noted at C5-7. There is tenderness noted upon palpation at the bilateral paravertebral area. Range of motion of the cervical spine was slightly limited due to pain. Pain was significantly increased with rotation. Sensory examination is within normal limits in the left upper extremity. Upper extremity flexor and extensor strength is unchanged from prior exam. Tinel's sign is positive on the right. Bilateral Tinel's sign at elbows are positive. Tenderness was noted upon palpation in the spinal vertebral area L5-S1 level. Range of motion of the lumbar spine showed decreased flexion limited to 30 degrees due to pain and extension limited to 10 degrees due to pain. Range of motion of the lumbar spine was slightly limited secondary to pain. Pain was significantly increased with flexion and extension Sensory exam shows decreased sensitivity to touch along the L5 dermatome in both lower extremities. Motor exam shows decreased strength of the extensor muscles along the L4-S1 dermatome in bilateral lower extremities. Straight leg raise in the seated position was positive on the left for radicular pain at 60 degrees and on the right for radicular pain at 40 degrees. Diagnoses include 1) cervical strain/sprain 2) sprain/strain of the thoracic spine 3) lumbar radiculopathy 4) chronic pain, other, 5) rule out right carpal tunnel syndrome and bilateral cubital tunnel syndrome.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral L4-5 Transforaminal Epidural Steroid Injection using fluoroscopy: Overturned

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

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

Decision rationale: Epidural steroid injections are recommended by the MTUS Guidelines when the patient's condition meets certain criteria. The criteria for use of epidural steroid injections include 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing 2) Initially unresponsive to conservative treatment 3) Injections should be performed using fluoroscopy for guidance 4) If used for diagnostic purposes, a maximum of two injections should be performed, and a second block is not recommended if there is inadequate response to the first block 5) No more than two nerve root levels should be injected using transforaminal blocks 6) No more than one interlaminar level should be injected at one session 7) In the therapeutic phase, repeat blocks 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, with a general recommendation of no more than 4 blocks per region per year 8) No more than 2 ESI injections. The requesting physician explains that MRI and EMG/NCS studies are consistent with bilateral L5 radiculopathy, reporting the following results. MRI of lumbar spine without contrast on 9/5/2012 identified 1) L3-4 minimal disc bulge without significant stenosis or neural compression 2) L4-5 mild disc bulge without significant stenosis or neural compression 3) L5-S1 minimal posterior protrusion of significant stenosis or neural compression 4) no compression fracture or bone marrow edema. EMG/NCS on 8/16/2012 was an abnormal study compatible with a bilateral L5 radiculopathy. The claims administrator had requested the EMG/NCS studies for review, but they were not provided. They are also not provided for this independent review, yet are reported by the requesting physician. The physical exam findings are significant for positive straight leg raise bilaterally, as well as myotome and dermatome neurological deficits in the L5 distribution bilaterally. The injured worker also reports 10/10 pain that is not relieved with medications. Medical necessity of this request has been established within the recommendations of the MTUS Guidelines. The request for Bilateral L4-5 Transforaminal Epidural Steroid Injection using fluoroscopy is determined to be medically necessary.