

Case Number:	CM14-0160240		
Date Assigned:	10/03/2014	Date of Injury:	10/02/2000
Decision Date:	11/04/2014	UR Denial Date:	09/12/2014
Priority:	Standard	Application Received:	09/30/2014

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:

The patient is a 69-year-old female who has submitted a claim for lumbosacral neuritis NOS associated with an industrial injury date of 10/2/2000. Medical records from 7/18/2014 up to 10/9/2014 were reviewed showing worsening lumbar radicular pain 7-8/10 in intensity. Physical examination of the lumbar spine revealed exaggerated lordosis, tenderness over the lower lumbar facet joints, and myofascial trigger points. Straight leg rise (SLR) was positive on the left. There was weakness with heel walking. There was decreased sensation over the lateral left and right legs. DTR of left ankle was slightly decreased. Magnetic resonance imaging (MRI) of the lumbar spine taken on 8/4/2014 revealed that the L5-S1 disc is intact with no foraminal narrowing. Facet arthropathy was noted on the right. There was grade 1 degenerative L4-L5 spondylolisthesis with moderate central canal stenosis, and moderate-severe right foraminal stenosis. Treatment to date has included tramadol ER and Norco. Utilization review from 9/12/2014 denied the request for 1 Left L5 and S1 transforaminal epidural steroid injection under fluoroscopy guidance. There was a lack of documentation showing that the patient had failed conservative treatment options including exercise, physical methods, NSAIDs, and muscle relaxants. In addition, given the date of injury of 10/2/2000, it is unclear if the patient had received epidural steroid injections in the past.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Left L5 and S1 transforaminal epidural steroid injection under fluoroscopy guidance:
Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs); Criteria for the use of Epidu.

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

Decision rationale: The California Medical Treatment Utilization Schedule (MTUS) Chronic Pain Treatment Guidelines recommend ESIs as an option for treatment of radicular pain. Most current guidelines recommend no more than 2 ESI injections. Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. The criteria for use of ESIs are: Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing; Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants); Injections should be performed using fluoroscopy (live x-ray) for guidance; No more than two nerve root levels should be injected using transforaminal blocks; 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. In this case, the patient complains of worsening lumbar radicular pain 7-8/10 in intensity. Physical examination of the lumbar spine revealed exaggerated lordosis, tenderness over the lower lumbar facet joints, and myofascial trigger points. SLR was positive on the left. There was decreased sensation over the lateral left and right legs. DTR of left ankle was slightly decreased. MRI of the lumbar spine taken on 8/4/2014 revealed that the L5-S1 disc is intact with no foraminal narrowing. There was grade 1 degenerative L4-L5 spondylolisthesis with moderate central canal stenosis, and moderate-severe right foraminal stenosis. However, the MRI of lumbar spine did not show foraminal narrowing of L5-S1. In addition, the imaging showed right foraminal stenosis of L4-L5 and not left foraminal stenosis as indicated in this request. Moreover, there was a lack of documentation showing that the patient had failed conservative treatment options including exercise, physical methods, NSAIDs, and muscle relaxants. Furthermore, given the date of injury of 10/2/2000, it is unclear if the patient had received epidural steroid injections in the past. Therefore the request for 1 Left L5 and S1 transforaminal epidural steroid injection under fluoroscopy guidance is not medically necessary.