

Case Number:	CM14-0219037		
Date Assigned:	01/09/2015	Date of Injury:	01/27/2011
Decision Date:	03/06/2015	UR Denial Date:	12/01/2014
Priority:	Standard	Application Received:	12/31/2014

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. 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: New York
 Certification(s)/Specialty: Emergency Medicine

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 54 year old male who sustained an industrial injury on 01/27/2011. He has reported subsequent lower back and left knee pain and was diagnosed with sciatica, displacement of lumbar intervertebral disc, spinal stenosis of the lumbar region and chronic meniscal tear of the knee. Reportedly, an MRI of the lumbar spine showed moderate to severe bilateral foraminal narrowing of L4-L5 and L5-S1 secondary to a posterior disc bulge and facet arthropathy. Additionally, an MRI of the left knee showed an oblique tear of the posterior horn of the medial meniscus. Although the treating physician documented that the Injured Worker had failed conservative treatment, there was no discussion as to which treatment modalities had been received, for how long the modalities had been attempted or the specific results of treatment. A progress note date 11/17/2014 documents the Injured Worker has continued low back and knee pain. Examination of the back noted normal strength, bulk and tone in all extremities. Sensation was noted to be intact in all dermatomal regions with full strength documented in all muscle groups. A knee examination noted medial joint line tenderness, a positive McMurray's test, and full range of motion. A request was made for a lumbar epidural steroid injection and a left knee cortisone injection for treatment of continued pain. The Injured Worker remains temporarily total disability. On 12/01/2014, Utilization Review non-certified requests for a lumbar epidural steroid injection at L4-L5 and a left knee cortisone injection. MTUS, ACOEM, and ODG guidelines were cited in support of this decision.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar Epidural at L4/5 QTY: 1: Upheld

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

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

Decision rationale: CA MTUS recommends epidural injections when a patient has symptoms, physical examination findings, and radiographic or electrodiagnostic evidence to support a radiculopathy. In this case, the radiographic findings do not show findings supportive of radiculopathy such as nerve root impingement. There are no electrodiagnostic studies included in the chart material. In addition, physical examination does not document any radiculopathy. Without these items, the request for epidural steroid injection is not medically necessary.

Left Knee Cortisone Injection x1: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 48, 339, 346. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Knee Chapter, Corticosteroid Injections, Criteria for Intraarticular Glucocorticosteroid Injections

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 13 Knee Complaints Page(s): 339. Decision based on Non-MTUS Citation Knee and Leg chapter

Decision rationale: According to CAMTUS ACOEM guidelines, cortisone injections are not routinely indicated. ODG guidelines indicate injections are recommended for short term use only. Injections are used specifically to treat osteoarthritic knee pain. ODG lists criteria to support the diagnosis of severe osteoarthritis. This includes knee pain, bony enlargements, bony tenderness, crepitus, morning stiffness, warmth of synovium, and age over 50. The reported MRI findings do not include arthritis in finding. Furthermore, the physical examination at the time of this request indicates the Injured Worker had full range of motion and there was not objective evidence of osteoarthritis documented. Without documented evidence to support the diagnosis of osteoarthritis, the request for a cortisone injection to the knee is not medically necessary.