

Case Number:	CM15-0108520		
Date Assigned:	06/15/2015	Date of Injury:	11/03/2000
Decision Date:	07/14/2015	UR Denial Date:	05/29/2015
Priority:	Standard	Application Received:	06/05/2015

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: Maryland

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Neuromuscular 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 58 year old female, who sustained an industrial injury on 11/3/2000. The current diagnoses are post-laminectomy syndrome of the lumbar spine, lumbago, sacroiliitis, lumbosacral spondylosis without myelopathy, spondylosis with myelopathy of the lumbar region, neuralgia, neuritis, and radiculitis, nerve root compression of the lumbar spine, lumbar facet syndrome, degeneration of the lumbar or lumbosacral intervertebral disc, and depression. According to the progress report dated 5/6/2015, the injured worker complains of low back pain. The pain is described a constant ache. The pain is rated 7/10 on a subjective pain scale. The physical examination of the lumbar spine reveals severe tenderness over the left sacroiliac joint, iliolumbar, hip, thigh, and leg with moderate tenderness over the right sacroiliac joint, iliolumbar, hip, thigh, and leg. There is restricted and painful range of motion. The medications prescribed are Nucynta, Flexeril, Ambien, and Benadryl. Treatment to date has included medication management, MRI studies, epidural steroid injection (improved pain more than 90%), and surgical intervention. The plan of care includes lumbar epidural injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar epidural injection, quantity: 1: Upheld

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

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

Decision rationale: Lumbar epidural injection, quantity: 1 is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The MTUS states that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. The request as written does not specify a level or laterality. Without clarification of the proposed level on the request and correlating objective findings on physical exam and imaging studies/electrodiagnostic testing for radiculopathy this request cannot be certified as medically necessary.