

Case Number:	CM15-0010825		
Date Assigned:	01/28/2015	Date of Injury:	04/26/2011
Decision Date:	03/18/2015	UR Denial Date:	01/19/2015
Priority:	Standard	Application Received:	01/20/2015

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: New Jersey, New York
Certification(s)/Specialty: Family Practice

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 65 year old male, who sustained an industrial injury on April 26, 2011. He has reported back pain. The diagnoses have included depressive disorder, anxiety disorder, male erectile disorder, insomnia, cervical spine sprain/strain, bilateral shoulder subacromial bursitis and biceps tendinitis, bilateral de Quervain's stenosing tenosynovitis, bilateral hip strain, intercostal neuralgia, lumbar myofascial pain, lumbar radiculopathy and lumbar disc protrusion. Treatment to date has included x-ray, electromyogram, pain management, epidural steroid injection and oral medication. Currently, the IW complains of neck pain with headaches, shoulder and wrist pain, low back and hip pain. Treatment includes oral medication. On January 19, 2015 utilization review non-certified a request for retro right lumbar selective nerve root block, noting no diagnostic studies showing lumbar radiculopathy. The Medical Treatment Utilization Schedule (MTUS) chronic pain guidelines were utilized in the determination. Application for independent medical review (IMR) is dated January 20, 2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Retro Right lumbar selective nerve root block: 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 Page(s): 46.

Decision rationale: The request for a right lumbar selective nerve block or diagnostic epidural steroid injection is not medically necessary. The guidelines state that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. In the chart, there isn't consistent documentation of exam findings that show a right-sided radiculopathy, corroborated by MRI findings. The findings are nonspecific and do not specify a certain dermatome. The electrodiagnostic testing he had showed polyneuropathy and not lumbar radiculopathy. Therefore, the request is considered medically unnecessary.