

Case Number:	CM15-0013776		
Date Assigned:	02/02/2015	Date of Injury:	02/08/2008
Decision Date:	03/30/2015	UR Denial Date:	01/08/2015
Priority:	Standard	Application Received:	01/23/2015

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: California, Arizona

Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 male who reported injury on 02/08/2008. The mechanism of injury was not provided. Other therapies included physical therapy and a home exercise program. The injured worker underwent knee surgery. The documentation of 12/01/2014 revealed the injured worker was in the office for a consultation. The injured worker was noted to have an injury that happened over a period of time. The injured worker was a traffic officer and had to wear 40 pounds of items including a gun and belt. Medications included Relafen 500 mg as needed and Norco 5/325 mg 1 by mouth twice a day with 90% to 100% pain relief for 2 to 3 hours. The injured worker was noted to have trialed chiropractic care. The documentation indicated the injured worker had an MRI in 2010. The objective findings revealed a positive straight leg raise at 30 to 45 degrees in an L3/L4 distribution on the right. There was moderate tenderness to palpation in the right lower lumbar paraspinal region and moderate pain with lumbar extension and the injured worker had an antalgic gait on the right. The diagnoses included lumbar DDD, lumbar spondylolisthesis, and lumbar radiculopathy. The treatment plan and discussion included the injured worker had a several year history of low back pain and right leg radicular leg symptoms and had trialed conservative care including physical therapy, NSAIDs, and Norco, but continued to have suboptimal pain relief. The physician documented the MRI revealed evidence of lumbar stenosis concordant with the pain symptoms. The injured worker would continue Norco 5/325 mg by mouth twice a day as needed for breakthrough pain. The request was made for a single right L3-4 and L4-5 transforaminal epidural steroid injection for treatment of lumbar radiculopathy. The MRI in 2010 revealed at the level of L4-5 there were

small bilateral disc bulges of 2 to 3 mm and a subtle left lateral annular tear that remained stable. There was moderate facet arthrosis with ligamentum flavum infolding. There was mild lateral recess stenosis without nerve root compromise of the proximal L5 nerve roots. The degree of left foraminal stenosis did contact but did not flatten the exiting L4 nerve root.

IMR ISSUES, DECISIONS AND RATIONALES

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

Transforaminal Epidural Steroid Injection, L4-L5, right side: Upheld

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

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

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend epidural steroid injections when there is documentation of objective findings of radiculopathy upon physical examination that are corroborated by imaging studies and that the injured worker's pain has been unresponsive to physical methods, exercise, NSAIDs, and muscle relaxants. The clinical documentation submitted for review indicated the injured worker had objective findings upon physical examination to support the level of L3-4. There was a lack of documentation indicating the injured worker had significant findings at L4-5. The MRI failed to indicate the injured worker had nerve root impingement. There was a lack of documentation of a failure of muscle relaxants. Given the above, the request for transforaminal epidural steroid injection, L4-5, right side is not medically necessary.