

Case Number:	CM15-0120607		
Date Assigned:	07/01/2015	Date of Injury:	04/25/2000
Decision Date:	07/30/2015	UR Denial Date:	05/23/2015
Priority:	Standard	Application Received:	06/22/2015

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: Massachusetts

Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 66 year old male, who sustained an industrial injury on 4/25/2000. The medical records submitted for this review did not include the details regarding the initial injury. Diagnoses include lumbar radiculopathy, cervical spondylosis without myelopathy, lumbar spondylosis and failed back surgical syndrome. Treatments to date include activity modification, NSAIDs, narcotic, joint injection, and physical therapy. Currently, he complained of low back pain with radiation into bilateral lower extremities. Pain was rated 10/10 VAS without medication and 5/10 VAS with medication. On 4/20/15, the physical examination documented abnormal lumbar range of motion, bilateral positive Patrick test and Thomas tests. There was tenderness to bilateral thoracic paraspinal muscles and lumbar facet joints. The treating diagnoses included lumbar spondylosis and radiculitis. The plan of care included transforaminal epidural steroid injections, right S1. The appeal requested review to authorize a right lumbar transforaminal epidural at L4 and L5.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 Right lumbar transforaminal epidural at 4, 5.: Upheld

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

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

Decision rationale: The claimant has a remote history of a work-related injury and continues to be treated for radiating low back pain. When seen, pain was rated at 5/10 with medications. There was decreased and painful lumbar range of motion. There was a normal lower extremity neurological examination and straight leg raising was negative. Criteria for the use of an epidural steroid injection include radiculopathy documented by physical examination and corroborated by imaging studies or electrodiagnostic testing. In this case, when seen there were no reported physical examination findings that would support a diagnosis of lumbar radiculopathy and the requested epidural steroid injection was not medically necessary.