

Case Number:	CM15-0061039		
Date Assigned:	04/07/2015	Date of Injury:	09/16/2014
Decision Date:	05/29/2015	UR Denial Date:	03/18/2015
Priority:	Standard	Application Received:	03/31/2015

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

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 46 year old male who sustained a work related injury September 16, 2014. While moving a ladder, he felt pain in his low back. Past history included left knee surgery, 2009. He has undergone 9 of 12 physical therapy sessions, which he believes have provided no benefit. MRI, dated January 23, 2015, revealed degenerative disc disease with anterior annular tear at L2-3 and L4-5. On 04/01/2015, the injured worker presented for an evaluation of his left lower extremity symptoms. He denied any changes from his previous visit and stated that he continued to have low back pain with pain with radiation into the left lower extremity. On examination, he had no abnormalities with his gait or station and musculoskeletal muscle tone was noted to be normal without any atrophy. Bilateral upper and lower extremity strength was 5/5. Deep tendon reflexes were symmetrically bilaterally to the patella and Achilles. There was no clonus sign noted bilaterally. He had normal lumbar flexion, extension, bilateral lateral bending and rotation to the right and left. Sensation was intact bilaterally in the lower extremities and straight leg raise was negative. Spasm and guarding was noted in the lumbar spine and motor strength was a 5/5. Diagnoses included lumbar disc displacement without myelopathy, pain psychogenic not elsewhere classified. Treatment plan included; speaking with physical therapy to complete remaining sessions (3) after epidural, request for authorization for trial of epidural steroid injections, L2-L3, L4-L5, each additional level x 2, lumbar epidurogram, fluoroscopic guidance and intravenous sedation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar epidural steroid injection at L2-L3, L4-L5: Upheld

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

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

Decision rationale: According to the California MTUS Guidelines, epidural steroid injections are recommended for those who have radicular symptoms on examination that is corroborated with imaging studies. There should also be documentation of failed conservative treatment. The documentation submitted for review does not show that the injured worker has any significant neurological deficits on examination such as decreased sensation or motor strength in a specific dermatomal or myotomal distribution that would support the medical necessity of an epidural steroid injection. Also, the provided MRI does not indicate that the injured worker has any significant neural compromise or nerve root impingement to support the medical necessity of this request. Without this information, the requested procedure would not be supported. Therefore, the request is not medically necessary.

Each additional level x2: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Lumbar epidurogram x1: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

Fluoroscopic guidance x1: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

IV sedation x1: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: The Expert Reviewer did not cite any medical evidence for its decision.

Decision rationale: Since the primary procedure is not medically necessary, none of the associated services are medically necessary.