MAXIMUS Federal Services

Case Number:	CM15-0070213		
Date Assigned:	04/17/2015	Date of Injury:	01/04/2006
Decision Date:	05/18/2015	UR Denial Date:	04/06/2015
Priority:	Standard	Application Received:	04/13/2015

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: Preventive Medicine, Occupational 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:

This 52 year old man sustained an industrial injury on 1/4/2006. The mechanism of injury is not detailed. Evaluations include left foot x-rays. Diagnoses include multilevel lumbar degenerative disc disease with L3-4 radiculopathy and status post L4-5 decompression surgery, left Achilles bursitis or tendinitis and left Achilles re-rupture. Comorbid conditions includes obesity (BMI 31.24). Treatment has included oral medications, epidural injections (which decreased pain [50% reduction documented at time of injection] and allowed for less use of opioid medications - effect lasted 8-10 weeks), and surgical intervention. Recent Lumbar CT myelogram showed moderate bilateral foraminal narrowing at site of previous L4-5 surgery but does not describe nerve impingement. Physician notes dated 3/24/2015 showed continued complaints of right sciatic pain, knee buckling, and a fall the day prior to that visit resulting in left Achilles re-rupture. No exam was documented. The most recent documented exam of lumbar spine was performed 26 Oct 2014 by a neurosurgeon as part of a QME evaluation and did not showed evidence of radiculopathy. Recommendations from 3/24/15 included evaluation for surgical intervention, CAM walker boot, and epidural injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral L4 & L5 transforaminal epidural steroid injection times 1 with conscious sedation and fluoroscopy: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 46.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 288, 309-10,Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs), Chronic Regional Pain Syndrome (sympathetic and epidural blocks) Page(s): 39-40, 46.

Decision rationale: The best medical evidence today for individuals with low back pain indicates that having the patient return to normal activities provides the best outcomes. Therapy should be guided, therefore, with modalities which will allow this outcome. Epidural steroid injections are an optional treatment for pain caused by nerve root inflammation as defined by pain in a specific dermatome pattern consistent with physical findings attributed to the same nerve root. As per the MTUS the present recommendations is for no more than 2 such injections, the second being done only if there is at least a partial response from the first injection. Its effects usually will offer the patient short term relief of symptoms as they do not usually provide relief past 3 months, so other treatment modalities are required to rehabilitate the patient's functional capacity. The MTUS provides very specific criteria for use of this therapy. Specifically, the presence of a radiculopathy documented by examination and corroborated by imaging, and evidence that the patient is unresponsive to conservative treatment. In the documented care for this patient, these criteria are not met. Even though the history is compatible with a possible radiculopathy, this is not supported by the exam, which is non-specific for a radiculopathy. Additionally, the degenerative changes in the lumbar spine noted on the lumbar CT melogram do not describe nerve impingement. There is no recent electromyography (EMG/NCV) to support the presence of a radiculopathy. Thus, the patient does not meet the criteria for this requested therapy. Medical necessity for this procedure has not been documented.