

Case Number:	CM15-0099518		
Date Assigned:	06/02/2015	Date of Injury:	04/26/2011
Decision Date:	07/01/2015	UR Denial Date:	05/14/2015
Priority:	Standard	Application Received:	05/22/2015

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: Texas, California
 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:

This is a 43 year old male patient, who sustained an industrial injury on 4/26/2011. Diagnoses include chronic thoracolumbar spine strain, chronic lumbar radicular syndrome and chronic lumbar disc protrusion at L5-S1. He sustained the injury due to a fall from a 3 steps footstool. Per the doctor's note dated 5/4/2014, the patient has continued to self treatment without improvement. The physical examination of the lumbar spine revealed tenderness, limited range of motion and negative straight leg raising test. Per the Primary Treating Physician's Progress Report dated 3/18/2015 he reported flare-ups to lower back pain with attempts to increase activity. Physical examination of the thoracic spine revealed tenderness to palpation over the upper, middle and paravertebral muscles. There was mild limitation of motion. Lumbar spine evaluation revealed tenderness to palpation over the upper, mid and lower paravertebral muscles. There was decreased range of motion and pain with lumbar flexion and extension. The medications list includes orudis, protonix and Tylenol #3. He has had lumbar epidural steroid injection in 12/2013 without improvement. He has had thoracic spine MRI in 8/2011 and lumbar MRI on 10/17/2013 which revealed minimal degenerative disc disease with disc dessication at L5-S1 and 2-3mm disc protrusion at L5-S1 with neural foraminal narrowing. He has had chiropractic care, home exercise and physical therapy visits for this injury. The plan of care included, and authorization was requested for magnetic resonance imaging (MRI) of the lumbar spine and a second lumbar epidural steroid injection at L5-S1.

IMR ISSUES, DECISIONS AND RATIONALES

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

MRI of the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303. Decision based on Non-MTUS Citation Official Disability Guidelines-Treatment in Workers' Compensation, Low Back Procedure Summary Online Version last updated 04/29/2015.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 303-304. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Chapter: Low Back (updated 05/15/15) MRIs (magnetic resonance imaging).

Decision rationale: Request: MRI of the lumbar spine. Per the ACOEM low back guidelines cited below "Unequivocal objective findings that identify specific nerve compromise on the neurologic examination are sufficient evidence to warrant imaging in patients who do not respond to treatment and who would consider surgery an option. When the neurologic examination is less clear, however, further physiologic evidence of nerve dysfunction should be obtained before ordering an imaging study. Indiscriminant imaging will result in false-positive findings, such as disk bulges, that are not the source of painful symptoms and do not warrant surgery. If physiologic evidence indicates tissue insult or nerve impairment, the practitioner can discuss with a consultant the selection of an imaging test to define a potential cause (magnetic resonance imaging [MRI] for neural or other soft tissue, computer tomography [CT] for bony structures)." The records provided do not specify any progression of neurological deficits for this patient. The history or physical exam findings do not indicate pathology including cancer, infection, or other red flags. In addition, per the records provided patient has already had lumbar MRI on 10/17/2013 which revealed minimal degenerative disc disease with disc desiccation at L5-S1 and 2-3mm disc protrusion at L5-S1 with neural foraminal narrowing. Per the cited guidelines "Repeat MRI is not routinely recommended, and should be reserved for a significant change in symptoms and/or findings suggestive of significant pathology (eg, tumor, infection, fracture, neurocompression, recurrent disc herniation)." Any significant change in the patient's condition since the last MRI that would require a repeat lumbar MRI is not specified in the records provided. Response to previous conservative therapy including physical therapy visits is not specified in the records provided. A recent lumbar spine X-ray report is also not specified in the records provided. The medical necessity of MRI of the lumbar spine is not fully established for this patient at this juncture.

Second lumbar epidural steroid injection at L5-S1: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46.

Decision rationale: Request-Second lumbar epidural steroid injection at L5-S1. The MTUS Chronic Pain Guidelines regarding Epidural Steroid Injections state, "The purpose of ESI is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program." Per the cited guideline criteria for ESI are "1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). 7) In the therapeutic phase, repeat blocks should be based on continued objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of medication use for six to eight weeks, with a general recommendation of no more than 4 blocks per region per year." Per the records provided patient had chronic lower back and thoracic pain and physical examination revealed tenderness and decreased range of motion of the lumbar and thoracic spine. Unequivocal evidence of radiculopathy documented by physical examination and corroborated by electro diagnostic testing is not specified in the records provided. He has had lumbar epidural steroid injection in 12/2013 without improvement. The records provided do not specify clear objective documentation of at least 50% improved functional response and decrease in need for pain medications, for a duration six to eight weeks with prior lumbar steroid injection. As stated above, epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. Failure to previous conservative therapy including physical therapy visits and pharmacotherapy is not specified in the records provided. As stated above, ESI alone offers no significant long-term functional benefit. The medical necessity of a Second lumbar epidural steroid injection at L5-S1 is not fully established for this patient.