

Case Number:	CM14-0145346		
Date Assigned:	09/12/2014	Date of Injury:	09/27/2013
Decision Date:	10/21/2014	UR Denial Date:	08/07/2014
Priority:	Standard	Application Received:	09/08/2014

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. The expert reviewer is Board Certified in Physical Medicine & Rehabilitation, has a subspecialty in Pain Management and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 24-year-old male reported an injury on 09/27/2013 due to an unknown mechanism. Diagnoses were resolved left leg sciatica, and persistent right leg sciatica. Past treatments were medications and physical therapy. Diagnostic studies were MRI of the lumbar spine on 06/30/2014 that revealed interval laminectomy and partial discectomy at L4-5, with resolved lateral recessed stenosis, residual 4 mm diffuse disc bulge, and moderate facet arthroses contribute to mild to moderate bilateral foraminal narrowing, slightly improved from prior. The remainder of the study appeared grossly unchanged, including L2-3 mild disc bulge and facet arthrosis resulting in mild bilateral foraminal stenosis, and L5-S1 disc bulge with superimposed left paracentral to foraminal disc protrusion and moderate facet arthrosis resulting in moderate bilateral foraminal narrowing. Physical examination on 09/05/2014 revealed the injured worker reported his right leg symptomology had diminished somewhat due to changing his shoe wear. The pain was reported to radiate into the right buttock and down the right leg to the calf and ankle area. Examination revealed the injured worker was able to sit more comfortably. He would arise from a chair with minimal support from the armrest. The injured worker ambulated with a subtle limp on the right, which tended to improve as he walked more in the room. He still had mild irritability with sitting straight leg raise on the right and negative on the left. Medications were Norco and Lyrica. The treatment plan was for a diagnostic right L4-5, L4-5 and L5-S1 transforaminal epidural steroid injection. The rationale and Request for Authorization were not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Diagnostic Right L4-5, L4-5-S1 Transforaminal Epidural Steroid Injection: 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 request for Diagnostic Right L4-5, L4-5-S1 Transforaminal Epidural Steroid Injection is not medically necessary. The California MTUS Guidelines state the purpose of Epidural Steroid Injection 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. Criteria for the use of Epidural Steroid Injections are radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. The injured worker should initially be unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). Injections should be performed using fluoroscopy (live x-ray) for guidance. If used for diagnostic purposes, a maximum of 2 injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least 1 to 2 weeks between injections. No more than 2 nerve roots level should be injected using transforaminal blocks. No more than 1 interlaminar level should be injected at 2 sessions. 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 6 to 8 weeks with a general recommendation of no more than 4 blocks per region per year. There was no examination of the spine. It was not reported that the injured worker was doing a home exercise program. It was not reported that the injured worker was to participate in a physical therapy program or some type of exercise program after the epidural steroid injection. The clinical information submitted for review does not provide evidence to justify a diagnostic right L4-5, L5-S1 transforaminal epidural steroid injection. Therefore, this request is not medically necessary.