

Case Number:	CM14-0173435		
Date Assigned:	10/24/2014	Date of Injury:	02/18/2014
Decision Date:	11/25/2014	UR Denial Date:	10/15/2014
Priority:	Standard	Application Received:	10/21/2014

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 and is licensed to practice in Illinois. 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 36-year-old female who reported an injury on 02/18/2014. The mechanism of injury was not provided. The injured worker has a diagnosis of lumbar sprain/strain. Past medical treatment included medications, chiropractic therapy, physical therapy and acupuncture. Diagnostic testing including x-rays, an MRI of the lumbar spine without contrast on 07/22/2014 and EMG/NCV on 08/20/2014; the MRI showed no compression fracture or significant marrow signal abnormalities were noted; L5-S1 level a 2 mm to 3 mm disc bulge was noted, which had mild left central focality; this extended to the ventral aspect of the thecal sac without causing central spinal canal stenosis; there was mild bilateral foraminal exit zone compromise, facet joint hypertrophy was noted; L4-5 level, there was a 4 mm to 5 mm central, left central and foraminal disc protrusion causing compression of the thecal sac from the left anterolateral aspect; mild central spinal canal stenosis and mild to moderate left foraminal exit zone compromise; mild right foraminal exit zone compromise is also noted; there is mild bilateral facet joint hypertrophy; L3-4 level, there is a 2 mm to 3 mm diffuse disc bulge which has central focality where it indents the thecal sac, without causing central spinal canal stenosis; no significant foraminal exit zone compromise; no significant facet joint arthropathy is noted; L2-3 level, there is a mild diffuse disc bulge not causing any significant central or nerve root canal stenosis; there is no significant facet joint hypertrophy; the uterus is slightly bulky with no definite fibroids noted. Surgical history was not provided. The injured worker complained of pain, which radiates to the left leg down the back of leg to the heel on 09/09/2014. The injured worker uses a cane intermittently. The physical examination revealed positive straight leg raise on left seated and supine. A positive EMG for L5 radiculopathy and a slight left limp. Medications were not provided. The treatment plan is for lumbar steroid injection. The rationale for the request was not submitted. The Request for Authorization form was not submitted.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar steroid injection: Upheld

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

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

Decision rationale: The California MTUS guidelines state epidural steroid injections are recommended as an option for treatment of radicular pain must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. The guidelines indicate 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. The documentation submitted for review indicates that the injured worker has had prior epidural steroid injections; however, the provided documentation does not indicate the levels at which prior injections were performed. There is a lack of documentation indicating whether the injured worker had at least 50% pain relief with associated reduction of medication use and improved function for six to eight weeks. Injections should be performed using fluoroscopy (live x-ray) for guidance. There is a lack of documentation indicating the injured worker has significant findings which demonstrate significant neurologic deficit upon physical examination. There is lack of documentation stating for what level the request is for. Therefore, the request for Lumbar steroid injection is not medically necessary.