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| Case Number: | CM14-0191122 | | |
| Date Assigned: | 11/24/2014 | Date of Injury: | 02/06/2009 |
| Decision Date: | 01/13/2015 | UR Denial Date: | 10/22/2014 |
| Priority: | Standard | Application Received: | 11/17/2014 |

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 Anesthesiology, has a subspecialty in Pain Management and is licensed to practice in Tennessee. 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 patient is a 68-year-old male who has submitted a claim for thoracic or lumbosacral neuritis or radiculitis associated with an industrial injury date of February 6, 2009. Medical records from 2014 were reviewed. The patient complained of low back pain radiating to bilateral lower extremities associated with numbness and tingling sensation. A physical examination showed tenderness over the paralumbar muscles, weakness of the left lower extremity muscles rated 4/5, normoreflexia, limited lumbar motion, positive straight leg raise test at the left, and diminished sensation at bilateral L5 and S1 dermatomes. The electrodiagnostic study from July 22, 2014 documented right S1 radiculopathy. The MRI of the lumbar spine from July 10, 2014 documented multilevel disk protrusion causing bilateral neural foramina stenoses that encroaches the left and right exiting L4 nerve roots. At L5-S1, there is a diffuse disk protrusion with effacement of the thecal sac. There is narrowing of the left neural foramina that effaces the left L5 exiting nerve root. Treatment to date has included medications, rest, chiropractic therapy and lumbar epidural steroid injection on September 4, 2014. He reported 30% pain relief after epidural steroid injection. The utilization review from October 22, 2014 denied the request for lumbar epidural steroid injection, left side L5 to S1 because the guideline recommends 50% pain relief from the previous procedure to warrant a repeat epidural steroid injection. There was also no documentation regarding associated reduction of medication use.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar Epidural Steroid Injection, Left Side L5-S1: Upheld

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

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

Decision rationale: As stated on page 46 of CA MTUS Chronic Pain Medical Treatment Guidelines, epidural steroid injection (ESI) is indicated among patients with radicular pain that has been unresponsive to initial conservative treatment. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 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. In this case, the patient complained of low back pain radiating to bilateral lower extremities associated with numbness and tingling sensation. Physical examination showed tenderness over the paralumbar muscles, weakness of the left lower extremity muscles rated 4/5, normoreflexia, limited lumbar motion, positive straight leg raise test at the left, and diminished sensation at bilateral L5 and S1 dermatomes. Symptoms persisted despite medications, rest and chiropractic therapy. The electrodiagnostic study from July 22, 2014 documented right S1 radiculopathy. The MRI of the lumbar spine from July 10, 2014 documented multilevel disk protrusion causing bilateral neural foramina stenoses that encroaches the left and right exiting L4 nerve roots. At L5-S1, there is a diffuse disk protrusion with effacement of the thecal sac. There is narrowing of the left neural foramina that effaces the left L5 exiting nerve root. Clinical manifestations are consistent with radiculopathy and corroborated by imaging findings. However, the patient underwent lumbar epidural steroid injection on September 4, 2014 resulting to 30% pain relief. The patient does not meet the guideline criterion of a minimum of 50% symptom relief to warrant a repeat injection. Any associated functional improvement is likewise not documented. There is no discussion concerning need for variance from the guidelines. Therefore, the request for lumbar epidural steroid injection, left side L5 to S1 is not medically necessary.