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| Case Number: | CM14-0023370 | | |
| Date Assigned: | 05/12/2014 | Date of Injury: | 09/08/2006 |
| Decision Date: | 03/16/2015 | UR Denial Date: | 02/20/2014 |
| Priority: | Standard | Application Received: | 02/24/2014 |

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. 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: 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:

The injured worker is a 50-year-old female who sustained an industrial injury on September 8, 2006. The injured worker is status post cervical fusion and right shoulder surgery. She is diagnosed with bilateral carpal tunnel syndrome, bilateral shoulder impingement, cervical radiculopathy, and lumbar discogenic disease. The injured worker was evaluated on December 17, 2013 at which time there was increased sciatic pain in the right L5 distribution. Utilization Review was performed on February 20, 2014 at which time it was noted that the physical examination is vague with respect to neurologic deficits. It was also noted that there is lack of clear documentation of magnetic resonance imaging and in fact new magnetic resonance imaging was requested indicating that the treating physician has unclear idea of the etiology of the symptoms. It was also noted that the levels requested to be injected were not addressed. The MTUS guidelines were cited. The medical records submitted for this review include a request for authorization dated April 30, 2013 at which time request is for lumbar epidural steroid injection times one bilateral at L5-S1. Examination report dated March 27, 2013 noted subjective complaints of low back pain radiating to the legs right greater than left. Physical examination revealed positive straight leg raise on the right at 45 degrees and on the left at 60 degrees, positive Lasegue bilaterally, motor weakness on the right at L4-L5 and decreased sensation bilaterally at L4-S1. A request was made for lumbar epidural steroid injection at L4-S1 bilaterally times three for worsening pain. It is noted that the injured worker had lumbar epidural steroid injection in the past which provided relief for six months. It was also noted that the injured worker has failed conservative therapy.

IMR ISSUES, DECISIONS AND RATIONALES

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

LUMBAR EPIDURAL INJECTION WITH 1CC CELESTONE AND 1CC MARCAINE:

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): 45-46.

Decision rationale: Per the MTUS guidelines, certain criteria must be met prior to proceeding with epidural steroid injections. The guidelines state that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing, 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 and current research does not support a “series-of-three” injections in either the diagnostic or therapeutic phase. In this case, the levels to be injected are not clearly noted and the reported neurological deficits are not corroborated with imaging or electrodiagnostic studies. Furthermore, the records state that the patient has undergone prior lumbar epidural steroid injections with six months relief. However, the records do not establish whether the reported pain relief was associated with objective functional improvement and medication reduction. The request for lumbar epidural injection is not medically necessary.