

Case Number:	CM15-0103934		
Date Assigned:	06/08/2015	Date of Injury:	04/25/2013
Decision Date:	07/08/2015	UR Denial Date:	05/01/2015
Priority:	Standard	Application Received:	05/29/2015

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: California
 Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 46-year-old male, with a reported date of injury of 04/25/2013. The diagnoses include lumbar radiculitis, low back pain, lumbar disc displacement/herniated nucleus pulposus, lumbosacral sprain/strain, and lumbosacral spondylosis with multilevel disc desiccation. Treatments to date have included an MRI of the lumbar spine on 08/05/2013 which showed desiccated L4-5 disc with bilateral facet joint arthropathy and retrolisthesis of L5 on S1 with moderately severe desiccated L5-S1 degenerative disc as well as bilateral facet joint arthropathy resulting in moderately severe bilateral neural foraminal stenosis with slight impingement on both L5 nerve roots; electrodiagnostic studies on 08/25/2014; epidural steroid injection at L5-S1 level without improvement; physical therapy without improvement; and oral medications. The medical report dated 04/20/2015 indicates that the injured had a chief complaint of low back and left lower limb pain. The physical examination showed use of a single point cane, no areas of tenderness to palpation in the lumbar region, decreased active range of the motion of the lumbar spine, positive left straight leg raise with positive dural tension signs, normal strength, and intact sensory examination. The treating physician requested a left L4-5 and L5-S1 transforaminal epidural steroid injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left L4-L5, L5-S1 Transforaminal Epidural Steroid Injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid injections, page 46.

Decision rationale: MTUS Chronic Pain Medical Treatment Guidelines recommend ESI as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy); however, radiculopathy must be documented on physical examination and corroborated by imaging studies and/or Electrodiagnostic testing. Although the patient has radicular symptoms; however, with intact motor strength and sensation, not meeting criteria for LESI. To repeat a LESI 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. Submitted reports are unclear with level of pain relief and duration of benefit without noted improvement. Submitted reports have not demonstrated any functional improvement derived from the LESI as the patient has unchanged symptom severity, unchanged clinical findings without decreased in medication profile or treatment utilization or functional improvement described in terms of increased functional status or activities of daily living. Criteria to repeat the LESI have not been met or established. The Left L4-L5, L5-S1 Transforaminal Epidural Steroid Injection is not medically necessary and appropriate.