

Case Number:	CM15-0181612		
Date Assigned:	09/22/2015	Date of Injury:	07/18/2011
Decision Date:	11/03/2015	UR Denial Date:	08/13/2015
Priority:	Standard	Application Received:	09/15/2015

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: New York, Pennsylvania, Washington
 Certification(s)/Specialty: Internal Medicine, Geriatric Medicine

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 54 year old male with an industrial injury date of 07-18-2011. Medical record review indicates he is being treated for post laminectomy syndrome, lumbar region, arachnoiditis and lumbar spondylosis and muscle spasm. Subjective complaints (07-27-2015) included lumbar pain described as remaining unchanged in character, intensity and location. The pain is described as "constant" but with a "variable intensity" depending on activity level. Location of the pain was documented as in the lower lumbar region with radiation to the bilateral lumbar musculature with radiation to bilateral hips and sacroiliac region. The injured worker described the pain as "dull, aching and sharp at times." Aggravating factors for pain are documented as prolonged sitting and standing, weight bearing activity and most "activities of daily living." The pain is documented as improving with rest, lying down and medications. Other complaints included bilateral lower extremity pain right greater than left. The pain was documented as radiating into the posterior extremities ending at the knee on the left and progressing into the foot on the right. The injured worker described the pain as "sharp, shooting, shocking and difficult to tolerate." Symptoms documented as being associated with the pain included loss of sensation in the right foot, "significant" weakness and "considerable" discomfort. The pain is noted to be aggravated by strenuous or prolonged activity and improved with lying down, resting and medications. Prior treatment included right lumbar 4, lumbar 5 and sacral 1 transforaminal epidural steroid injection with 80% pain reduction in pain times 3 weeks. Past medications included Acetaminophen - "ineffective", Neurontin - "nausea", and Lyrica - "rash on hands." Other past medications documented as helpful included Opana, Lidoderm patch

and Soma. His medications included Oxycodone-Acetaminophen, Ibuprofen, Lyrica and Gabapentin (07-27-2015). Lyrica was stopped (with tapering) at the 07-27-2015 visit. Prior treatments documented included lumbar surgery, physical therapy medications, epidural steroid injection and spinal cord stimulator. Diagnostic reports documented by the treating physician in the 07-27-2015 note included: MRI of lumbar spine 09-19-2014 - (1) Lumbar 5-sacral 1 post-operative changes with clumping and distortion of the nerve roots of the cauda equina at lumbar 4-sacral 1 compatible with arachnoid adhesions, Moderate right and mild left foraminal stenosis secondary to an annular bulge, right foraminal protrusion and facet spurring, Mild narrowing the left sacral 1 lateral recess. (2) Lumbar 4-5 mild right foraminal stenosis and effacement of thecal sac. Electromyography and nerve conduction studies of bilateral lower extremity 07-30-2014 - (1) Abnormal study. (2) There is electro diagnostic evidence for acute, ongoing right lumbar radiculopathy along the lumbar 4, lumbar 5 and sacral 1 distribution. (3) There is no evidence for peripheral polyneuropathy. Physical exam in the 07-27-2015 note is documented as exam date 06-08--2015. Exam findings are documented as: Lumbar reflexes-Right lumbar 5 internal hamstrings 0, left lumbar 5 internal hamstrings 2, right sacral 1 Achilles 0 and left sacral 1 Achilles 2. Sensory was documented as decreased in right lumbar 4, right lumbar 5 and right sacral 1. Strength was documented as right lumbar 4 - 4, left lumbar 4 - 5, right lumbar 5 - 4 and left lumbar 5-5. Straight leg raise was positive at 70 degrees to the toes on the right. Facet loading - Increased pain with extension and rotation bilaterally. The requested treatment is for lumbar transforaminal epidural steroid injection at L 4, L 5 and S 1. On 08-13-2015 the request for lumbar transforaminal epidural steroid injection at L 4, L 5 and S 1 was non-certified by utilization review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar transforaminal epidural steroid injection at L4, L5 and S1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

Decision rationale: Per the guidelines, epidural spine injections are recommended as an option for treatment of radicular pain. Most current guidelines recommend no more than 2 injections. Epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. There is little information on improved function. The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months, and there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain. Though the physical exam does suggest radicular pathology, the worker does not meet the criteria as there is not clear evidence in the records that the worker has failed conservative treatment with exercises, physical methods, NSAIDS and muscle relaxants. The epidural injection is not medically necessary.

