

Case Number:	CM15-0189759		
Date Assigned:	10/02/2015	Date of Injury:	09/23/2013
Decision Date:	11/13/2015	UR Denial Date:	08/26/2015
Priority:	Standard	Application Received:	09/25/2015

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 40 year old female, who sustained an industrial injury on 9-23-2013. The injured worker was diagnosed as having lumbar disc displacement, lumbar radiculopathy, lumbar sprain-strain, and myofascial pain syndrome. Treatment to date has included diagnostics, acupuncture, physical therapy, and medications. On 8-13-2015, the injured worker complains of ongoing pain in her low back, left lower extremity, and left shoulder (not rated). Objective findings regarding the lumbar spine included lumbosacral tenderness to palpation with myofascial tightness, painful range of motion, and positive straight leg raise on the left. Deep tendon reflexes were equal in the bilateral lower extremities. Shoulder findings were also documented. She was advised to continue Tylenol (over the counter) and do exercises at no pain range. Work status was temporary partial disability. Diagnostic testing results for the lumbar spine were not referenced. Per the Request for Authorization dated 8-13-2015, the treatment plan included a lumbar epidural steroid injection (unspecified), non-certified by Utilization Review on 8-26-2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar Epidural Steroid Injection: 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: Based on the 8/13/15 progress report provided by the treating physician, this patient presents with ongoing low back pain, left lower extremity pain, and left shoulder pain. The treater has asked for lumbar epidural steroid injection on 8/13/15. The patient's diagnoses per request for authorization dated 8/19/15 are lumbar disc displacement, lumbar radiculopathy, lumbar sprain/strain, and MPS. The patient is currently using Tylenol per 7/16/15 report. The patient also has insomnia/general anxiety disorder per 1/28/15 report. The patient has history of migraines and does not have a surgical history related to her back, left lower extremity, or left shoulder per review of reports. The patient's work status is temporarily totally disabled per 8/13/15 report. MTUS Guidelines, Epidural Steroid Injections section, page 46: "Criteria for the use of Epidural steroid injections: 1. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 3. Injections should be performed using fluoroscopy (live x-ray) for guidance. 8) Current research does not support a 'series-of-three' injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections." 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. The treater is requesting an epidural steroid injection "to help the patient control her pain and discomfort" per requesting 8/13/15 report. The utilization review letter dated 8/26/15 denies request due to lack of imaging to support pathology contributory to radiculopathy, and because treater does not specify a level of treatment or laterality. In this case, the patient presents with radicular back pain and left lower extremity pain with a positive straight leg raise. However, review of reports does not show the patient has had a lumbar MRI to date. In addition, the treater does not specify the level of the requested epidural steroid injection. Therefore, the request IS NOT medically necessary.