

<b>Case Number:</b>	CM15-0201897		
<b>Date Assigned:</b>	10/16/2015	<b>Date of Injury:</b>	10/07/2002
<b>Decision Date:</b>	11/25/2015	<b>UR Denial Date:</b>	10/01/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	10/14/2015

### 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 43 year old male, who sustained an industrial injury on 10-07-2002. A review of the medical records indicates that the injured worker (IW) is undergoing treatment for chronic low back pain with L4-5 and L5-S1 herniated disc. Medical records (06-29-2015 to 09-29-2015) indicate ongoing low back pain which is worse on the right and radiates to the right posterior thigh. Pain levels were rated 6-9 out of 10 in severity on a visual analog scale (VAS). Records also indicate no changes in activity levels or level of functioning. The IW's work status was not specified. The PR, dated 09-29-2015, revealed no physical exam findings. Relevant treatments have included: lumbar laminectomy surgeries (x2), physical therapy (PT), one epidural steroid injection (mid 2000s), chiropractic treatments, acupuncture, work restrictions, and pain medications. The treating physician indicates that MRI of the lumbar spine (08-2015) showed a progressed broad-based posterior disc protrusion at L4-5 resulting in moderate lateral recess and neural foraminal narrowing, a stable focal right paracentral disc protrusion at L5-S1 resulting in moderate right neural foraminal and lateral recess narrowing, and a prior right-sided laminectomy at L5-S1. The request for authorization (09-29-2015) shows that the following treatment was requested: 3 lumbar interlaminar injections. The original utilization review (09-30-2015) non-certified the request for 3 lumbar interlaminar injections.

### IMR ISSUES, DECISIONS AND RATIONALES

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

### **3 lumbar interlaminar injections: Upheld**

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

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

**Decision rationale:** MTUS Chronic Pain Medical Treatment Guidelines recommend nerve root block 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. Submitted reports have demonstrated correlating radicular findings and neurological deficits to support the interlaminar injections. There is also no identified failed conservative care or indication to support for three interlaminar injections, beyond guidelines criteria limiting to no more than two levels for transforaminal and no more than one level for interlaminar blocks at one session without repeated series of three. There is no report of acute new injury, flare-up, or red-flag conditions to support for pain procedure having completed a functional restoration program. Criteria for the epidurals have not been met or established. The 3 lumbar interlaminar injections is not medically necessary and appropriate.