MAXIMUS Federal Services

Case Number:	CM15-0202859		
Date Assigned:	10/19/2015	Date of Injury:	08/03/2006
Decision Date:	11/30/2015	UR Denial Date:	09/16/2015
Priority:	Standard	Application Received:	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: Massachusetts
Certification(s)/Specialty: Physical Medicine & Rehabilitation, Pain Management

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 45 year old female who sustained an industrial injury on 8-3-06. The injured worker reported bilateral thumb trigger and low back pain with lower extremity radiation and neck pain with upper extremity radiation. A review of the medical records indicates that the injured worker is undergoing treatments for post-traumatic cervical spine sprain strain, mild tendinosis and tenosynovitis of flexor pollicis longus tendon and lumbar spine sprain strain. Medical records dated 3-30-15 indicate "continued low back pain." Provider documentation dated 3-30-15 noted the work status as temporary totally disabled. Treatment has included status post right carpal tunnel release (10-19-11), magnetic resonance imaging, and lumbar spine epidural steroid injection. Objective findings dated 3-30-15 were notable for cervical spine loss of lordosis and decreased range of motion, lumbar spine with inability to ambulate on heels and toes secondary to pain and decreased range of motion. The original utilization review (9-16-15) denied a request for Second Lumbar Epidural Steroid Injection (LESI).

IMR ISSUES, DECISIONS AND RATIONALES

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

Second Lumbar Epidural Steroid Injection (LESI): Overturned

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: The claimant sustained a cumulative trauma work injury with date of injury in August 2006. A lumbar epidural steroid injection was done in February 2015. In March 2015 there had been relief after the lumbar epidural steroid injection. She underwent gastric bypass 9 days after the injection. She was having radiating low back pain to bilateral lower extremities with numbness and tingling. There was decreased and painful lumbar range of motion. She had difficulty transitioning positions. There was a guarded posture. She was unable to ambulate on her heels or toes due to pain. Straight leg raising was positive bilaterally. There was decreased right lower extremity sensation and decreased bilateral first toe extension strength. An MRI is referenced as showing n L4/5 disc protrusion with L4 nerve displacement. A second lumbar epidural steroid injection is being requested. In terms of lumbar epidural steroid injections, guidelines recommend that, in the diagnostic phase, a maximum of two injections should be performed. A repeat block is not recommended if there is inadequate response to the first block. A second block is also not indicated if the first block is accurately placed unless there is a question of the pain generator, there was possibility of inaccurate placement, or there is evidence of multilevel pathology. In these cases a different level or approach might be proposed. There should be an interval of at least one to two weeks between injections. In this case, the claimant had reported relief after the first injection done more than one month before. She has radicular symptoms and physical examination findings of radiculopathy with positive straight leg raising and decreased lower extremity strength and sensation. Further epidural steroid injections would be dependent on the duration and degree of resulting pain relief. A second diagnostic epidural steroid injection is medically necessary.