

Case Number:	CM15-0211791		
Date Assigned:	10/30/2015	Date of Injury:	04/07/2005
Decision Date:	12/14/2015	UR Denial Date:	10/22/2015
Priority:	Standard	Application Received:	10/28/2015

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: North Carolina

Certification(s)/Specialty: Family Practice

CLINICAL CASE SUMMARY

The expert reviewer developed the following clinical case summary based on a review of the case file, including all medical records:

This is a 51-year-old male who sustained a work-related injury on 4-7-05. Medical record documentation on 10-8-15 revealed the injured worker was being treated for status post lumbar fusion, status post lumbar laminectomy, lumbar disc syndrome, left lower extremity radicular symptoms, and intermittent right L5 radicular symptoms. He reported continued improvement following his 7-6-15 epidural steroid injection and noted he had been able to decrease his medications. He was able to wean use of Ultram by 50% and weaned Lyrica an additional 50%. He reported continued exercise activity and tried to avoid aggravations. He reported dull achiness in the low back on a near constant basis and continued to have frequent radicular and neuropathic pain in the bilateral lower extremities. Objective findings included tenderness to palpation over the lumbar paraspinal muscles with taut muscle bands and no spasms noted. His range of motion had improved to 50 degrees with forward flexion and 15 degrees with extension. He had a positive straight leg raise with continued hypoesthesia along the S1 dermatomal pattern. He had difficulty with heel-toe walking due to weakness. An MRI of the lumbar spine on 2-25-15 was documented as revealing intact surgical hardware post lumbar discectomy and fusion of L4-5 and L5-S1 and healing of the lateral bony fusion mass with moderate narrowing of both neuroforaminal. Previous treatment included lumbar epidural steroid injection on 8-4-14 providing 50 % improvement for over 16 weeks directed at right S1, lumbar epidural steroid injection on 4-28-15 which provided 60-70% improvement for over eight weeks, and lumbar epidural steroid injection on 7-6-15 which provided 70% improvement for two to three weeks and remained greater than 50% improvement eight weeks later. A request for outpatient repeat

lumbar epidural steroid injection - caudal approach was received on 10-16-15. On 10-22-15, the Utilization Review physician determined outpatient repeat lumbar epidural steroid injection - caudal approach was not medically necessary.

IMR ISSUES, DECISIONS AND RATIONALES

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

Repeat Lumbar Epidural steroid injection(ESI) - Caudal approach: Overturned

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: The California chronic pain medical treatment guidelines section on epidural steroid injections (ESI) states: Criteria for the use of Epidural steroid injections: Note: The purpose of ESI is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress in more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). 3) Injections should be performed using fluoroscopy (live x-ray) for guidance. 4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections. 5) No more than two nerve root levels should be injected using transforaminal blocks. 6) No more than one interlaminar level should be injected at one session. 7) 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. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007) 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. The provided clinical documentation for review shows previous ESI produced 60-70% pain reduction with reduction in medication usage. Therefore, repeat ESI is medically necessary.