

Case Number:	CM15-0221196		
Date Assigned:	11/16/2015	Date of Injury:	03/13/2003
Decision Date:	12/31/2015	UR Denial Date:	10/28/2015
Priority:	Standard	Application Received:	11/10/2015

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 62 year old male, who sustained an industrial injury on 3-13-2003. The injured worker was being treated for L2-L3 spinal stenosis with neurogenic claudication and L3-L4 post laminectomy retrolisthesis with foraminal stenosis and left L3 radiculitis. Treatment to date has included diagnostics, L3-4 and L4-5 laminectomy, right L2-3 and L3-4 selective nerve block on 8-28-2014, left L2-3 transforaminal block on 3-12-2015, and medications. On 10-19-2015, the injured worker complains of left leg pain worse than low back pain. Pain radiated into his posterior thigh and involved the anteromedial aspect of his left knee and calf. Pain was not rated. The treating provider noted "excellent response" to the transforaminal block 3-2015, not specified. Exam noted positive left sciatic nerve and femoral nerve stretch test. Lower extremity strength was 5 of 5 in all muscle groups, deep tendon reflexes were 1+ at the knees and ankles, and lumbar flexibility was restricted to 45 degrees of flexion and 20 degrees of extension. X-rays were documented to show "retrolisthesis of L2 on L3 and L3 on L4". Lumbar magnetic resonance imaging (3-19-2014) was documented as showing "evidence of bilateral foraminal stenosis at L2-3 and L3-4". Current medication regimen was not noted. Function with activities of daily living was not described. Work status was not noted. The treatment plan included a repeat left L2-L3 transforaminal steroid injection. On 10-28-2015 Utilization Review non-certified a request for a left L2-3 transforaminal epidural steroid injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left L2-3 transforaminal epidural steroid injection: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back, Epidural steroid injections, therapeutic, Pain Chapter, Epidural steroid injections.

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

Decision rationale: The claimant has a remote history of a work injury in March 2003 and underwent a lumbar laminectomy in March 2006. In April 2014, he had increasing right anterior thigh and knee pain over the past 6-12 months. An MRI of the lumbar spine in March 2014 had shown adjacent segment degeneration with right lateralized canal narrowing. There was multilevel bilateral mild to moderate neural compromise and compression. He underwent right selective nerve root blocks at L2/3 and L3/4 in August 2014. In January 2015, there had been several months of significant, temporary pain relief. He was taking Norco one time per day. He had bilateral buttock and anteromedial thigh pain. A two level left transforaminal epidural steroid injection was planned and was done on 03/12/15. In April 2015, there had been an excellent response to the injection. He was getting pain relief with Norco. In October 2015, he was having left leg pain radiating to the posterior thigh and anteromedial knee and calf. He was still taking Norco one time per day. Physical examination findings included positive left sciatic nerve stretch testing. There was normal lower extremity strength with symmetric reflexes. There was decreased lumbar range of motion. A repeat left L2/3 transforaminal epidural steroid injection was requested. In the therapeutic phase guidelines recommend that a repeat epidural steroid injection 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. In this case, the degree and duration of pain relief following the previous injection is not documented. There appears to have been no change in medication use with Norco being taken once per day. There are no physical examination findings such as decreased strength or sensation in a myotomal or dermatomal pattern or asymmetric reflex response that supports a diagnosis of radiculopathy. For these reasons, the requested repeat epidural steroid injection is not medically necessary.