

Case Number:	CM14-0170388		
Date Assigned:	10/20/2014	Date of Injury:	08/13/2003
Decision Date:	11/20/2014	UR Denial Date:	09/30/2014
Priority:	Standard	Application Received:	10/15/2014

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. The expert reviewer is Board Certified in Occupational Medicine and is licensed to practice in California. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

CLINICAL CASE SUMMARY

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

Injured worker is a male with date of injury 8/13/2003. Per initial workers' compensation comprehensive pain management consultation dated 9/10/2014, the injured worker complains of low back pain with radiation to the left lower extremity. He states he received physical therapy and analgesic medication and subsequently a lumbar epidural steroid injection without significant relief. Due to the persistent nature of his symptoms, he underwent microdiscectomy in March 2004. He states surgery did not provide significant pain relief, and the pain worsened after surgery. He underwent spinal cord stimulator trial in 2005 which did not provide significant relief. He tried physical therapy and a lumbar epidural steroid injection. Due to persistent pain, he underwent lumbar spine fusion in 2007 which did not provide any significant pain relief. In December 2012 he underwent microdiscectomy with 50% improvement for approximately two months. He has been taking Neurontin 300 mg two tablets four times a day and Norco 5/325 mg one tablet four times a day with provides 30% pain relief. He attended physical therapy from March to April 2013. He currently complains of low back pain that radiates to the left lower extremity and left groin. He also complains of weakness as well as numbness in the right anterior leg and foot. On examination he is in no acute distress. Range of motion of the thoracolumbar spine is reduced in all planes. Heel toe walking is difficult on the left. Lower extremity strength is 5/5 bilaterally. Patellar reflexes are 1+ on the left and 2+ on the right. Sensation is decreased to pinprick and light touch in the left lateral/anterior/posterior leg. Gait is normal without list or limp. There is tenderness to palpation on the left side from L3 through S1. There was no frank swelling, ecchymosis, discoloration or spasm appreciated. There is no significant tenderness overlying bilateral sciatic notches or sacroiliac joints. Diagnoses include 1) low back pain 2) lumbar radiculopathy 3) status post lumbar spine fusion 4) lumbar degenerative disc disease.

IMR ISSUES, DECISIONS AND RATIONALES

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

Left L4-L5, L5-S1 transforaminal epidural with fluoroscopy: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46.

Decision rationale: Epidural steroid injections are recommended by the MTUS Guidelines when the patient's condition meets certain criteria. The criteria for use of epidural steroid injections include 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing 2) Initially unresponsive to conservative treatment 3) Injections should be performed using fluoroscopy for guidance 4) If used for diagnostic purposes, a maximum of two injections should be performed, and a second block is not recommended if there is inadequate response to the first block 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 8) No more than 2 ESI injections. The injured worker has had an adequate response to ESI previously, so repeat injections are not recommended. Medical necessity has not been established within the recommendations of the MTUS Guidelines. The request for Left L4-L5, L5-S1 transforaminal epidural with fluoroscopy is determined to not be medically necessary.