

Case Number:	CM15-0179640		
Date Assigned:	09/21/2015	Date of Injury:	06/19/2012
Decision Date:	10/23/2015	UR Denial Date:	08/11/2015
Priority:	Standard	Application Received:	09/11/2015

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 51 year old male, who sustained an industrial injury on 06-19-2012. A review of the medical records indicates that the injured worker (IW) is undergoing treatment for lumbar degenerative disc disease, lumbar disc displacement, and lumbago with sciatica. Medical records (02-19-2015 to 07-30-2015) indicate ongoing low back pain with radiating pain to the left leg. Records also indicate no changes in activities of daily. Per the treating physician's progress report (PR), the IW has not returned to work. Relevant treatments have included physical therapy (PT), 4 previous epidural steroid injections to the low back with partial relief, work restrictions, and pain medications. The injured worker underwent a left L5-S1 transforaminal epidural steroid injection on 03-20-2015 with resulting in a reported 50% decrease in low back pain. Prior to the injection (PR dated 02-19-2015), the IW reported pain levels of 9 out of 10, and after the injection (PR dated 04-16-2015) pain levels were rated 5 out of 10. The physical exams, dated 04-16-2015 and 07-30-2015, revealed no changes in range of motion in the low back and no further decreases in pain levels. The treating physician indicates that a MRI of the lumbar spine (no date) showed left paracentral herniation at L5-S1 resulting in left lateral recess stenosis, and retrolisthesis with sever disc degeneration and some minor degeneration with a broad-based disc protrusion at L4-5. The request for authorization shows that one selective nerve block injection (SNBI) to the left lumbar L5-S1 under fluoroscopy was requested on. The original utilization review (08-11-2015) denied the request for the SNBI at the left L5-S1 under fluoroscopy based on the lack of documented lumbar neurological deficits on exam, and absence of electrodiagnostic testing supportive of radiculopathy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Injection Selective nerve block to left lumbar L5-S1 under flouroscopy qty 1: Upheld

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 claimant sustained a work injury in June 2012 and continues to be treated for low back pain with left lower extremity radiating symptoms. Treatments are referenced as having included at least four epidural injections with partial relief. On 03/20/15 pain was rated as high as 9/10. He underwent a left L5/S1 transforaminal epidural steroid injection. In April 2015 pain was rated as high as 5/10. When seen in August 2015, pain was again rated as high as 5/10. He was having back pain as well as radicular leg pain. Physical examination findings included normal strength and sensation with symmetrical reflex responses. There was left paraspinal tenderness. His BMI was over 27. Authorization was requested for another epidural injection. 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 claimant had pain relief after the injection in March of less than 50% by reported VAS scores, and there is no increase in pain being reported since that procedure. Additionally, there are no current physical examination findings such as decreased strength or sensation in a myotomal or dermatomal pattern or asymmetric reflex response that support a current diagnosis of radiculopathy. The requested repeat lumbar epidural steroid injection is not considered medically necessary.