MAXIMUS Federal Services

Case Number:	CM15-0025953		
Date Assigned:	02/18/2015	Date of Injury:	08/19/2014
Decision Date:	04/02/2015	UR Denial Date:	01/29/2015
Priority:	Standard	Application Received:	02/11/2015

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: California, Hawaii
Certification(s)/Specialty: Physical Medicine & Rehabilitation

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 40-year-old female, with a reported date of injury of 08/19/2014.The diagnoses include lumbosacral radiculitis/radiculopathy and myofascial pain syndrome. Treatments have included medications, L3-4 epidural steroid injection in 12/2014, with good relief of leg pain, an MRI of the lumbar spine on 10/20/2014, physical therapy, and acupuncture. The progress report dated 01/20/2015 indicates that the injured worker complained of low back pain and left leg pain with numbness and tingling. She rated her pain 6 out of 10. The pain was returning after the previous lumbar epidural steroid injection. An examination of the lumbar spine showed multiple tender points and trigger points, reduced and painful range of motion, positive left straight left raise test with radicular pain, reduced sensation in left L4 dermatome to light touch and pinprick, and normal motor strength. The treating physician requested a repeat left eccentric L3-L4 interlaminar epidural steroid injection. The rationale for the request was not indicated. On 01/29/2015, Utilization Review (UR) denied the request for a repeat left eccentric L3-L4 interlaminar epidural steroid injection, noting that there was no documentation of functional improvement and a reduction in pain medication for 6 to 8 weeks from the prior epidural. The MTUS Chronic Pain Guidelines were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Repeat left eccentric L3-L4 interlaminar Epidural Steroid Injection QTY 1: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection, criteria for use of Epidural Steroid Injection (ESIs) Page(s): 46.

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

Decision rationale: The patient presents with low back pain and left leg pain with numbness and tingling. The pain was returning after the previous lumbar epidural steroid injection. The prior ESI completed in 12/2014 provided "good relief of leg pain, 60% for about six weeks." The current request is for Repeat left eccentric L3-L4 interlaminar Epidural Steroid Injection QTY 1. The treating physician on 1/20/15 (C4) states, "request authorization for second injection left eccentric L3 to L4 interlaminar ESI." It appears the patient's condition has worsened due to "holding a student's had who unexpectedly jumped up and down and then dropped down to the floor" (B4). An orthopedic consultation lead to a proposed surgical intervention consisting of a transforaminal lumbar inter body fusion at L3-L4 to address both backs and leg symptoms, which the patient has declined (B11). MTUS Guidelines state, "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." In this case, the treating physician has documented the patient's prior ESI and the pain relief derived from the treatment as well as the current failure of conservative therapy (B8). Therefore, the current request is medically necessary and the recommendation is for authorization.