

<b>Case Number:</b>	CM15-0061512		
<b>Date Assigned:</b>	04/07/2015	<b>Date of Injury:</b>	01/24/1995
<b>Decision Date:</b>	05/29/2015	<b>UR Denial Date:</b>	03/04/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/01/2015

### 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, Washington

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 47 year old male who suffered an industrial injury on 01/24/1995. The mechanism of injury involved a fall. The diagnoses included lumbar spot laminectomy syndrome and displacement of lumbar disc without myelopathy. On 2/24/2015 the treating provider reported constant lower back pain, left buttock pain and posterior thigh pain rated 7/10. The injured worker reported occasional radiating pain into the left lower extremity. The injured worker had been previously treated with a lumbar epidural steroid injection. The injured worker was utilizing tramadol 50 mg for pain. Upon examination of the lumbar spine, there was decreased extension of 10 degrees, flexion to 45 degrees, positive straight leg raising on the left at 60 degrees, tenderness over the spinous process from L2 to L5, trigger points, and decreased sensation to pinprick in the L5 distribution on the left. The left Achilles deep tendon reflexes were diminished at ¼. Treatment recommendations at that time included a second lumbar epidural steroid injection with caudal catheter placement, lysis of adhesions, and epidurography. A Request for Authorization form was submitted on 02/25/2015.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Left L5-S1 transforaminal Epidural Steroid injection, quantity 2: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter, Percutaneous Adhesiolysis.

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

**Decision rationale:** The California MTUS Guidelines state epidural steroid injections are recommended as an option for treatment of radicular pain, with use in conjunction with active rehabilitation. In this case, the provider noted positive straight leg raising on the left, decreased sensation in the left L5 distribution, and diminished left side deep tendon reflexes. However, there was no indication that this injured worker was actively participating in a rehabilitation/exercise program. Furthermore, it was noted that the injured worker had been previously treated with a lumbar epidural steroid injection. The guidelines recommend a repeat block based on continued objective documented pain and functional improvement, including at least 50% pain relief with an associated reduction of medication use. In the absence of significant functional improvement, an additional procedure would not be supported. The request for 2 epidural steroid injections would not be supported as the injured worker's response to the initial injection would need to be documented prior to the administration of a second injection. Given the above, this request is not medically necessary.

**Left L5-S1 Transforaminal Epidural Steroid injection additional, quantity 2: Upheld**

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines, Low Back Chapter, Percutaneous Adhesiolysis.

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

**Decision rationale:** The California MTUS Guidelines state epidural steroid injections are recommended as an option for treatment of radicular pain, with use in conjunction with active rehabilitation. In this case, the provider noted positive straight leg raising on the left, decreased sensation in the left L5 distribution, and diminished left sided deep tendon reflexes. However, there was no indication that this injured worker was actively participating in a rehabilitation/exercise program. Furthermore, it was noted that the injured worker had been previously treated with a lumbar epidural steroid injection. The guidelines recommend a repeat block based on continued objective documented pain and functional improvement, including at least 50% pain relief with an associated reduction of medication use. In the absence of significant functional improvement, an additional procedure would not be supported. The request for 2 epidural steroid injections would not be supported as the injured worker's response to the initial injection would need to be documented prior to the administration of a second injection. Given the above, this request is not medically necessary.

**Caudal Catheter placement and lysis of Adhesions quantity 2: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Epidurography quantity 2:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**Fluoroguide for Spine, quantity 2:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.

**IV Sedation quantity 2:** Upheld

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** The Expert Reviewer did not cite any medical evidence for its decision.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.