

Case Number:	CM15-0074171		
Date Assigned:	04/24/2015	Date of Injury:	10/28/1995
Decision Date:	05/27/2015	UR Denial Date:	03/17/2015
Priority:	Standard	Application Received:	04/17/2015

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: Georgia

Certification(s)/Specialty: Anesthesiology, 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 71 year old male who sustained a work related injury October 28, 1995, when he was struck in the back by a pickup truck with injuries to his back, neck, and extremities. Past history included back surgery, right shoulder surgery x 2, and right thumb surgery. According to a supplemental report on pain management progress, dated March 4, 2015, the injured worker presented for follow-up with complaints of pain across his low back belt line extending into his bilateral sacroiliac joints and coccyx region, rated 7/10. He has been traveling and more active, causing more pain in his low back extending into his buttocks. He reports new and recent loss of bladder control. Palpation of the lumbar facets reveals pain on both sides L3-S1 region. Palpation of the bilateral sacroiliac joint area reveals right and left sided pain and palpable twitch positive trigger points in the lumbar paraspinal muscles. His gait appears antalgic and noted pain with lumbar extension. Diagnoses are lumbar spine radiculopathy; muscle spasm; cervical radiculopathy; sacroiliac sprain/strain; failed back syndrome, lumbar; unspecified neuralgia, neuritis, and radiculitis. Treatment plan included continuation of prescribed medication and random urine drug screen. At issue, is the request for lumbar epidural steroid injection at the left T-L junction for left L1 radiculopathy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar Epidural Steroid Injection at left T-L junction (thoracolumbar junction) for left L1 radiculopathy: Upheld

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

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection Page(s): 47.

Decision rationale: Lumbar Epidural Steroid Injection at left T-L junction (thoracolumbar junction) for left L1 radiculopathy is not medically necessary. The California MTUS page 47 states "the purpose of epidural steroid injections 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 is no significant long-term functional benefit. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Initially unresponsive to conservative treatment, injections should be performed using fluoroscopy, if the ESI is for diagnostic purposes a maximum of 2 injections should be performed. No more than 2 nerve root levels should be injected using transforaminal blocks. No more than 1 interlaminar level should be injected at one session. 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 6-8 weeks, with the general recommendation of no more than 4 blocks per region per year. Current research does not support a series of 3 injections in either the diagnostic or therapeutic phase. We recommend no more than 2 epidural steroid injections." The physical exam and MRI are not consistent with nerve root compression requiring an epidural steroid injection at this level. The request is not medically necessary.