

Case Number:	CM13-0043729		
Date Assigned:	12/27/2013	Date of Injury:	09/17/2012
Decision Date:	05/14/2014	UR Denial Date:	10/23/2013
Priority:	Standard	Application Received:	10/31/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Anesthesiology, has a subspecialty in Acupuncture and Pain 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 physician 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:

This is a 50 year old male injured worker with date of injury 9/17/12. Injury was to his neck and low back. X-ray of the cervical spine dated 8/6/12 revealed degenerative changes of the lower cervical spine. MRI of the cervical spine dated 9/20/12 revealed midline disc protrusion slightly indenting the cord with associated trace edema or myelopathy and posterolateral disc osteophyte complexes that mildly narrow the bilateral neural foramina, right greater than left at C3-C4; bilateral disc protrusion at C6- C7 mildly narrow the proximal neural foramina. MRI of the lumbar spine dated 09/24/12 revealed a multi-level disc disease was present; right sided posterior extruded fragment at the T12-L1 level mildly compressing the conus medullaris upper caudal equina, with significance questionable; severe spinal stenosis at the L3-L4 and L4-L5 levels from the disc bulging and ligamentous and facet hypertrophy; exiting nerve roots are clearly compressed at the level. He was refractory to physical therapy, which helped his headaches a little bit, but his neck and bilateral arm pain was unchanged. He was also refractory to injection in the lumbar spine, it made his pre-existing pain more intense. The date of UR decision was 10/23/13.

IMR ISSUES, DECISIONS AND RATIONALES

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

INJECTION, ANESTHETIC AGENT AND/OR STEROID, TRANSFORAMINAL EPIDURAL, WITH IMAGING AND GUIDANCE (FLUOROSCOPT OR CT); LUMBAR OR SACRAL, SINGLE LEVEL: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines SECTION EPIDURAL STEROID INJECTIONS.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines SECTION EPIDURAL STEROID INJECTIONS Page(s): 46.

Decision rationale: According to the MTUS Chronic Pain Medical Treatment Guidelines, epidural steroid injections are used 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 benefit. The criteria for the use of epidural steroid injections are as follows: 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) The pain must be initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). 3) Injections should be performed using fluoroscopy (live x-ray) for guidance. 4) If used for diagnostic purposes, a maximum of two injections should be performed. A second block is not recommended if there is inadequate response to the first block. Diagnostic blocks should be at an interval of at least one to two weeks between injections. 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) Current research does not support a "series-of-three" injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections. Review of the submitted documentation yielded no evidence of radiculopathy in physical exam findings. According to the 10/8/13 note, previous lumbar spine injection did not help, and actually made the pre-existing pain more intense. The request is not medically necessary.