

Case Number:	CM14-0110874		
Date Assigned:	08/01/2014	Date of Injury:	10/03/2002
Decision Date:	09/11/2014	UR Denial Date:	06/30/2014
Priority:	Standard	Application Received:	07/16/2014

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. The expert reviewer is Board Certified in Physical Medicine and Rehabilitation 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 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/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:

The injured worker is a 52-year-old female who reported an injury on 10/03/2002 due to a crush injury to the right leg resulting in amputation. Diagnoses were status post pedestrian versus motor vehicle accident, status post left above knee amputation, bilateral carpal tunnel syndrome, mechanical lumbar spine pain with herniated disc at L5-S1 with bilateral foraminal narrowing, chronic neurogenic pain left lower extremity, degenerative joint disease right knee, right saphenous nerve laceration of the mid-thigh, chronic edema, right lower extremity, scar disfigurement, and contracture in the soft tissues of the right thigh. Past treatment plans were not reported. Diagnostic studies of an EMG which was normal, and MRI which revealed lumbar spine on the L5-S1 disc extrusion and facet arthropathy also it revealed at the C5-6 disc protrusion C4-5 extruded disc fragment. The injured worker has had an extensive history of surgeries that added up to be around 38. Examination revealed the stump has been recreated with a posterior leg flap. On the right side there was extensive scarring up and down the leg. There was hypertrophy of the remaining tissues. The injured worker's hands had arthritis at the carpometacarpal joints on both sides. She had full range of motion of bilateral shoulders but had slight rotator cuff tendonitis. Medications for the injured worker were Wellbutrin XR 100mg, BuSpar 15mg, and Ativan 1mg. Treatment plan was for updated prostheses for the leg, seat lift for her chair. The rationale and Request for Authorization were not submitted for review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Transforaminal epidural injection at L4- L5: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIS).

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

Decision rationale: The California Medical Treatment Utilization Schedule states "epidural steroid injections are recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). The purpose of epidural steroid injection 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." The criterion for epidural steroid injection is that there must be documented radiculopathy and there should be a physical examination with corroborating image studies and/or electrodiagnostic testing. The injured worker should be initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs, and muscle relaxants). Injections should be performed using fluoroscopy (live x-ray) for guidance. If used for diagnostic purposes, a maximum of 2 injections should be performed. A second block is not recommended if there is an adequate response to the first block. Diagnostic blocks should be at an interval of at least 1 to 2 weeks between injections. No more than 2 nerve root levels should be injected using transforaminal blocks. No more than 1 interlaminar level should be injected at 1 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 to 8 weeks, with a general recommendation of no more than 4 blocks per region per year. The injured worker's physical examination did not reveal any signs of radiculopathy. There were no neurological deficits reported. Past conservative treatments were not submitted for review. Therefore, the request for Transforaminal Epidural Injection at the L4-L5 is not medically necessary.

Transforaminal epidural injection at L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46.

Decision rationale: The California Medical Treatment Utilization Schedule states "epidural steroid injections are recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). The purpose of epidural steroid injection 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." The criteria for epidural steroid injection are that there must be documented radiculopathy and there should be a physical examination with corroborating image studies and/or electrodiagnostic testing. The injured worker should be initially unresponsive to conservative treatment (exercises, physical methods,

NSAIDs, and muscle relaxants). Injections should be performed using fluoroscopy (live x-ray) for guidance. If used for diagnostic purposes, a maximum of 2 injections should be performed. A second block is not recommended if there is an adequate response to the first block. Diagnostic blocks should be at an interval of at least 1 to 2 weeks between injections. No more than 2 nerve root levels should be injected using transforaminal blocks. No more than 1 interlaminar level should be injected at 1 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 to 8 weeks, with a general recommendation of no more than 4 blocks per region per year. The injured worker's physical examination did not reveal any signs of radiculopathy. There were no neurological deficits reported. Past conservative treatments were not submitted for review. Therefore, the request for Transforaminal Epidural Injection at the L5-S1 is not medically necessary.