

Case Number:	CM14-0031654		
Date Assigned:	06/20/2014	Date of Injury:	06/11/2012
Decision Date:	08/19/2014	UR Denial Date:	03/04/2014
Priority:	Standard	Application Received:	03/13/2014

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 Texas and Ohio. 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 55-year-old male who reported an injury on 06/11/2012 due to a motor vehicle accident. The injured worker had a history of neck and lower back pain along with lower right leg weakness. The injured worker had diagnoses of back strain to the lumbar spine, muscle spasms, lumbar radiculopathy, lumbar discogenic spine pain, and cervical discogenic spine pain. The injured worker had a lumbar epidural steroid injection at the L5-S1 dated 11/30/2013 and again on 01/30/2013. The diagnostics were noted in the 05/07/2014 clinical note, indicating the injured worker had an EMG/NCS and an MRI of the right leg. No images were available for review. The past treatment included physical therapy of unknown visits, epidural steroid injections, and Norco pain medication. Medication included Neurontin 300 mg and Norco 10/325 mg. Per the 04/14/2014 clinical notes, the injured worker rated his pain at 3/10 on good days, current pain was a 4/10, and previous pain rating was a 9/10 to the lower back and lower extremities. The treatment plan included decrease pain level, improve mobility, improve self-care, increase recreational activities, and increase physical activities. The request for authorization dated 06/20/2014 was submitted within the documentation. No rationale was provided.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral lumbar transforaminal epidural injection at L4-L5 under flourosopic guidance with anesthesia: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300 and table 12-8, Chronic Pain Treatment Guidelines Chronic Pain Medical Treatment Guidelines; Epidural Steroid Injections Article: Avoiding Catastrophic Complications from Epidural Steroid Injections.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain , Epidural Steroid Injection.

Decision rationale: The California MTUS recommend epidural steroid injections as an option for treatment for radicular pain. The current guidelines recommend no more than 2 epidural steroid injections. This is a contraindication to the previously generally cited recommendations for a series of 3 epidural steroid injections. Current recommendations suggest a second epidural steroid injection if partial success is produced with the first injection, and a third epidural steroid injection is rarely recommended. An epidural steroid injection can offer short term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. There is little information on improved function. The criteria for a epidural steroid injection includes radiculopathy that must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing, initially unresponsive to conservative treatment, and injections should be performed using fluoroscopy for guidance. If the epidural steroid injection is for diagnostic purposes, then a maximum of 2 injections should be performed. The second would not be recommended if there was inadequate response to the first. The diagnostic blocks should be at intervals of at least 1 to 2 weeks between injections. For a therapeutic phase, repeat blocks should be based on continuous objective documented pain and functional improvement, including at least 50% pain relief with associated reduction of the medication use for 6 to 8 weeks with a general recommendation of no more than 4 blocks per region per year. Current research does not support the series of 3 injections in either the diagnostic or therapeutic phase. It is recommended no more than 2 injections. Per the documentation provided, the injured worker already received 2 epidural steroid injections; however, documentation was unclear how the injured worker responded to the epidural steroid injections. Furthermore, there was no evidence that the injured worker was unresponsive to conservative treatment. The injured worker's pain level had reduced to a functioning level. The physical therapy clinical notes were not submitted. The MRI was not provided within the documentation. The Official Disability Guidelines indicate that there is no evidence-based literature to make a firm recommendation as to sedation during an epidural steroid injection. The use of sedation induces some potential diagnostic and safety issues, making unnecessary use less than ideal. The major concern is that sedation may result in the inability of the injured worker to experience the expected pain associated with the spinal cord irritation. As such, the request is not medically necessary.