

Case Number:	CM14-0092645		
Date Assigned:	07/25/2014	Date of Injury:	08/02/2013
Decision Date:	09/26/2014	UR Denial Date:	06/12/2014
Priority:	Standard	Application Received:	06/18/2014

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 Family Medicine and is licensed to practice in New Jersey. 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 worker is a 50-year-old female who was injured on August 2, 2013. She was diagnosed with lumbar pain, lumbar discogenic myofascial pain, bilateral lumbar radicular syndrome, and lumbar spine dysfunction. She was treated with chiropractic treatments, oral medications. MRI of the lumbar spine was performed on March 31, 2014 which showed a disc bulge (3mm) at the L5-S1 level producing a mild central canal narrowing and moderate to severe right neural foraminal narrowing and severe left neural foraminal narrowing, and at the L4-5 level, another 3mm disc bulge with mild central canal narrowing and moderate right and left foraminal narrowing. On May 1, 2014, the worker was seen by her pain management physician (initial evaluation) complaining of her low back pain with radiation down the legs with numbness and pins and needles sensation in the right foot. There was also reported difficulties with bowel and bladder as well as sexual activities. Physical examination of the lumbar spine revealed inability to walk on toes or heels, pelvic tilt to the left, restricted range of motion, straight leg raise positive on the right, no tenderness, normal sensation of the lower extremities, slight weakness of right dorsiflexors, and slight decrease in right knee deep tendon reflex. It was then recommended to receive a bilateral L5 epidural steroid injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Epidural Steroid Injection Bilateral L5: Overturned

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 injections Page(s): 46.

Decision rationale: The Chronic Pain Medical Treatment Guidelines state that epidural steroid injections are recommended as an option for treatment of lumbar radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) and can offer short-term pain relief, but use should be in conjunction with other rehab efforts, including continuing a home exercise program. The criteria as stated in the MTUS Guidelines for epidural steroid injection use for chronic pain includes the following: 1. radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing, 2. Initially unresponsive to conservative treatment (exercise, physical methods, NSAIDs, and muscle relaxants), 3. Injections should be performed using fluoroscopy 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, and 8. Current research does not support a "series-of-three" injections in either the diagnostic or therapeutic phase, and instead only up to 2 injections are recommended. In the case of this worker, there seems to be enough evidence of fulfilling the criteria for considering an epidural injection. Therefore, the bilateral epidural injection at the L5 level is appropriate and medically necessary.