

Case Number:	CM13-0058122		
Date Assigned:	12/30/2013	Date of Injury:	11/01/2011
Decision Date:	04/16/2015	UR Denial Date:	11/22/2013
Priority:	Standard	Application Received:	11/26/2013

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: New Jersey

Certification(s)/Specialty: Family Practice

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 35-year-old male, who sustained an industrial injury on 11/01/2011. Initial complaints reported included back and neck pain due to lifting heavy objects. The initial diagnoses were not provided. Treatment to date has included conservative care, medication management, MRIs of the cervical and lumbar spines (2012), radiographic imaging of the lumbar spine, electrodiagnostic testing of the bilateral upper extremities (01/21/2013), physical therapy, consultations, and lumbar epidural injection (7/19/2013). Currently, the injured worker complains of neck and low back pain (improving since last injection), and pain in the right knee with weakness. Current diagnoses include lumbar radiculopathy, cervical facet syndrome, cervical disc degeneration, disc disorder of the cervical spine, disc disorder of the lumbar spine, cervical pain, cervical radiculopathy, lumbago, and lumbar facet syndrome. The current treatment plan includes continued medications and home exercise program, bilateral lumbar epidural steroid injections, and cervical epidural steroid injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral L4-5 lumbar Epidural Steroid Injection with Fluoroscopy: Upheld

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

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

Decision rationale: The MTUS 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 was a previous epidural injection at the L4-5 level done months prior with a minimal follow-up report on how effective it was. However, the reported pain level was 5/10 on the pain scale both before the injection and afterwards, suggesting that it was not very effective. Therefore, the repeat lumbar epidural at L4-5 will be considered medically unnecessary, considering the evidence presented.

Cervical Epidural Steroid Injection: Upheld

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

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

Decision rationale: The MTUS 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 was no EMG/NCV report or cervical spine MRI report to corroborate the physical findings. In addition, the physical findings were too broad and could have been related to carpal tunnel and ulnar nerve entrapment and not cervical radiculopathy. Without more clear physical findings and imaging/nerve testing findings to confirm the diagnosis, epidural injection will be considered medically unnecessary. In addition, the request did not include a cervical level to be injected.