

Case Number:	CM14-0197038		
Date Assigned:	12/05/2014	Date of Injury:	11/01/2012
Decision Date:	01/22/2015	UR Denial Date:	10/29/2014
Priority:	Standard	Application Received:	11/24/2014

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 Preventive Medicine, and is licensed to practice in Indiana. 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:

This is a 35 year old male with a work injury dated 11/01/2012. The only record submitted is dated 10/20/2014. The injured worker (IW) was complaining of increasing pain over the past few weeks in the lower back and knee radiating into both legs with right knee pain. Physical exam revealed right para-lumbar spasm with one plus to two plus tenderness along the right para-lumbar musculature. There was two plus tenderness over the distal lumbar spine. One to two plus sciatic notch tenderness was noted along with two plus right sacral 1 joint tenderness. There was slight left sciatic notch tenderness without left sacral 1 joint tenderness. Lower extremity straight leg raising caused right knee pain. Straight leg raising on the left was negative. MRI of the lumbar spine on 01/02/2013 revealed a lumbar 5-sacral 1 left paracentral disc protrusion which contacts the left sacral 1 nerve root and epidural lipomatosis which caused mild thecal sac narrowing in the mid and lower lumbar spine. The MRI report is not in the submitted documents. The IW had received an epidural injection "a little over a year ago." He stated he had improvement in back, lower extremity and knee pain with epidural injection. The provider notes review of the report from 09/24/2013 "which also noted the same response." He had been able to control his pain with ibuprofen periodically until recently. He had been treating the right knee pain with ibuprofen, using Norco for severe pain. He stated he had run out of the medication about 3 weeks prior to the office visit. Diagnoses included:-Lumbar degenerative disc disease with worsening pain-Right knee Chondromalacia On 10/20/2014 the provider requested a consultation and epidural steroid injection. On 10/29/2014 utilization review issued a non-certification for the epidural steroid injection stating the medical records did not contain evidence of acute neurologic or orthopedic impairment or functional impairment that would require an epidural steroid injection. Utilization review also non-certified the request for consultation stating the epidural steroid injection was not certified therefore, the follow up

consultation was not medically reasonable, necessary or appropriate. Guidelines cited were Chronic Pain Medical Treatment Guidelines, Low back Complaints (ACOEM Practice Guidelines 2nd edition 2004 Chapter 12) and Official Disability Guidelines: Work Loss Data Institute LLC; Corpus Christi, TX; Low back lumbar and thoracic. The decision was appealed to Independent Medical Review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Follow-up consultation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315, Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Epidural steroid injections (ESIs), therapeutic

Decision rationale: MTUS Chronic pain medical treatment guidelines state that epidural steroid injections are "Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) . . . 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 were no medical documents provided to conclude that other rehab efforts or home exercise program is ongoing. Additionally, no objective findings were documented to specify the dermatomal distribution of pain. MTUS further defines the criteria for epidural steroid injections to include: 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) 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. (Manchikanti, 2003) (CMS, 2004) (Boswell, 2007) 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. The request for ESI is not medically necessary, so the request for a follow up consultation is not medically necessary.

ESI injection (level not specified): Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints, Chronic Pain Treatment Guidelines. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)

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