MAXIMUS Federal Services

Case Number:	CM14-0197450		
Date Assigned:	12/05/2014	Date of Injury:	11/04/2013
Decision Date:	01/20/2015	UR Denial Date:	11/10/2014
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 Anesthesiology, has a subspecialty in Pain Medicine and is licensed to practice in Georgia. 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 51-year-old female presenting with a work-related injury on November 4, 2013. The injured worker was diagnosed with lumbar degenerative disc disease. MRI of the lumbar spine on November 13, 2013 was significant for L5 - S1 2 to 3 mm protrusion with annular tear that mildly flattens the anterior thecal sac. There are minimal left neural foramina narrowing; at L4-5 there is a 4 mm protrusion that mildly flattens the anterior thecal sac without nerve root, canal or foraminal stenosis. On October 31, 2014 the injured worker complained of back pain with tenderness to palpation to the sacroiliac joints. The pain radiates to the buttocks and posterior thigh to the heel with occasional numbness and tingling. The injured worker had 17 sessions of physical therapy with some relief but pain persists. The physical exam was significant for positive straight leg raise on the left and right at 60; pain to palpation of the sacroiliac joints and paraspinal muscles. A claim was made for bilateral L5-S1 transforaminal epidural steroid injection with fluoroscopy and monitored sedation. The provider noted that the injured worker has difficulty lying still and requires sedation the procedure.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral L5-S1 Transforaminal Epidural Steroidal Injection with Fluoroscopy and Monitored Anesthesia: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Guidelines Epidural Steroid Injection Page(s): 47. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Pain Chapter, Treatment Consideration

Decision rationale: Bilateral L5-S1 Transforaminal Epidural Steroidal Injection with Fluoroscopy and Monitored Anesthesia is not medically necessary. The California MTUS page 47 states "the purpose of epidural steroid injections 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 is no significant long-term functional benefit. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Initially unresponsive to conservative treatment, injections should be performed using fluoroscopy; if the ESI is for diagnostic purposes a maximum of 2 injections should be performed. No more than 2 nerve root levels should be injected using transforaminal blocks. No more than 1 interlaminar level should be injected at one 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 6-8 weeks, with the general recommendation of no more than 4 blocks per region per year. Current research does not support a series of 3 injections in either the diagnostic or therapeutic phase. We recommend no more than 2 epidural steroid injections." The ODG states that in terms of sedation with epidural steroid injections, the use of IV sedation (including other agents such as Modafinil) may interfere with the result of the diagnostic block, and should only be given in cases of extreme anxiety. Additionally, a major concern is that sedation may result in the inability of the patient to experience the expected pain and parathesias associated with spinal cord irritation. The claimant's physical exam and MRI is consistent with radiculopathy in the distribution of the epidural treatment level; however, anesthesia is not recommended with epidural steroid injection as it takes away the patients protective defenses and there is lack of documentation of extreme anxiety. Per ODG and CA MTUS guidelines, the requested procedure is not medically necessary.