

Case Number:	CM15-0001489		
Date Assigned:	01/12/2015	Date of Injury:	07/30/2014
Decision Date:	03/04/2015	UR Denial Date:	12/09/2014
Priority:	Standard	Application Received:	01/05/2015

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: Ohio, North Carolina, Virginia
 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 49 year old male with a date of injury of 8-1-2014. He developed neck pain and low back pain after lifting a bundle of pipes. He subsequently developed left lower extremity pain of a radicular nature. He failed to improve with medication and physical therapy. The physical exam revealed tenderness of the lumbar paraspinal muscles and the sacroiliac joint. There was diminished lumbar range of motion. There was diminished strength of the left extensor hallucis longus and soleus muscles. Sensation was within normal limits. The straight leg raise exam was positive on the left at 60 degrees. An MRI scan revealed a disc protrusion at L3-L4 with evidence of L3 nerve root impingement on the right. At L5-S1 there is a paracentral diffuse annular disc bulge with signal loss or dessication. There was no central or foraminal stenosis at that level. At issue is a request for a left sided L5-S1 epidural steroid injection. Utilization review non-certified this request because of the lack of physical evidence of radiculopathy.

IMR ISSUES, DECISIONS AND RATIONALES

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

Epidural Injection at Left L5-S1: Overturned

Claims Administrator guideline: Decision based on MTUS ACOEM Page(s): 308-310.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS.
Decision based on Non-MTUS Citation Low back

Decision rationale: Diagnostic epidural steroid transforaminal injections are also referred to as selective nerve root blocks, and they were originally developed as a diagnostic technique to determine the level of radicular pain. When used for diagnostic purposes the following indications have been recommended: 1) To determine the level of radicular pain, in cases where diagnostic imaging is ambiguous, including the examples below; 2) To help to evaluate a radicular pain generator when physical signs and symptoms differ from that found on imaging studies; 3) To help to determine pain generators when there is evidence of multi-level nerve root compression; 4) To help to determine pain generators when clinical findings are consistent with radiculopathy (e.g., dermatomal distribution) but imaging studies are inconclusive; 5) To help to identify the origin of pain in patients who have had previous spinal surgery. Therapeutically, the criteria for lumbar epidural steroid injections are more stringent. Criteria for the use of Epidural steroid injections: Note: The purpose of ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, reduction of medication use and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. (1) Radiculopathy (due to herniated nucleus pulposus, but not spinal stenosis) must be documented. Objective findings on examination need to be present. Radiculopathy must be 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) and injection of contrast for guidance. (4) Diagnostic Phase: At the time of initial use of an ESI (formally referred to as the 'diagnostic phase' as initial injections indicate whether success will be obtained with this treatment intervention), a maximum of one to two injections should be performed. A repeat block is not recommended if there is inadequate response to the first block (< 30% is a standard placebo response). A second block is also not indicated if the first block is accurately placed unless: (a) there is a question of the pain generator; (b) there was possibility of inaccurate placement; or (c) there is evidence of multilevel pathology. In these cases a different level or approach might be proposed. There should be an interval of at least one to two weeks between injections. In this case, the symptoms are left sided but the imaging study supports right sided pathology. The physical exam does support a possible left sided L5 radiculopathy. Therefore, a diagnostic epidural steroid injection at left L5-S1 is medically necessary.