MAXIMUS Federal Services

Case Number:	CM15-0165332		
Date Assigned:	09/02/2015	Date of Injury:	10/10/2012
Decision Date:	10/06/2015	UR Denial Date:	07/31/2015
Priority:	Standard	Application Received:	08/24/2015

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: Arizona, California
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 10-10-12. Initial complaints were of his neck and back due to a motor vehicle accident. The injured worker was diagnosed as having failed back surgery syndrome; chronic low back pain post-surgery; radiculopathy; erectile dysfunction; gastric reflux due to medications; left ulnar neuropathy; bilateral carpal tunnel syndrome. Treatment to date has included status post lumbar surgery (2012); physical therapy; medications. Diagnostics studies included MRI lumbar spine (6-26-15); MRI cervical spine (5-17-13; 6-15-15); MRI thoracic spine (7-15-15); MRI lumbar spine (6-26-15); EMG-NCV study bilateral upper extremities. Currently, the PR-2 notes dated 7-15-15 indicated the injured worker complains of neck, thoracic and lumbar pain. He also complains of bilateral shoulder pain with numbness and tingling in the bilateral upper extremities and radiating pain in the bilateral upper extremities and lower extremities and erectile dysfunction. He has had lumbar surgery in 2012 but continues radiating pain and with back pain. He rates his pain as 5 out of 10 with Ibuprofen. He reports radiating pain in the bilateral lower extremities, calf, his feet, bilateral buttocks, but no significant weakness. He reports he has had erectile dysfunction since surgery and was diagnosed with irritable bowel syndrome. The provider notes an EMG-NCV study diagnosed nerve damage in the peroneal area. He complains of severe neck pain rated at 6 out of 10 radiating to the upper extremities. An EMG-NCV study of the upper extremities diagnosed moderate to severe bilateral carpal tunnel syndrome and left ulnar neuropathy but no nerve damage coming from the neck. He is currently going to school for his bachelors in psychology and planning to go to the PA program. On physical examination there is

tenderness to palpation in the entire cervical spine, trapezius bilaterally and shoulders. He has tenderness to palpation in the mod and low thoracic area. The lumbar spine examination shows a 2cm vertical incision with tenderness to palpation in the lumbar spine, paraspinals, and gluteals. His forward flexion is to 80 degrees, extension to 10 degrees and causing pain. His straight leg raising is equivocal bilaterally. He has intermittent tingling sensation in the bilateral lower extremities in different areas mostly the last two digits of the right foot. A MRI of the cervical spine on 6-15-15 shows posterior disc bulges of 2mm at C3-4 and 3mm at C5-6 with mild right C5-6 neuroforaminal narrowing. Anterior C3-4 and C4-5 spondylosis with anterior osteophytes noted at this level. A MRI of the thoracic spine dated 6-15-15 shows a 2mm posterior disc bulge at T7-8 and T10-11 without any evidence of central or lateral stenosis. A MRI of the lumbar spine dated 6-26-15 shows posterior disc bulges of 2mm each at L2-3 and annular fissures and posterior disc bulges of 3-4mm at L4-5 and 4-5mm at L5-S1 with mild central canal narrowing at L4-5 and L5-S1 and small amount of epidural fibrosis at L4-5. Status post laminectomy right L4-5 is noted and moderate left L5-S1 facet hypertrophy. There is neuroforaminal narrowing which is mild on the right L4-5 and on the left L5-S1 with mild to moderate right L5-S1 neuroforaminal narrowing. The provider is requesting authorization of Transforaminal epidural steroid injection: Bilateral S1 x 1 and Transforaminal epidural steroid injection: Bilateral C5 x 1.

IMR ISSUES, DECISIONS AND RATIONALES

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

Transforaminal epidural steroid injection: Bilateral S1 x 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections. Decision based on Non-MTUS Citation Official Disability Guidelines in Workers Compensation, Epidural Steroid Injections.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines epidural injections Page(s): 47.

Decision rationale: According to the guidelines, the criteria for the use of Epidural steroid injections: Note: The purpose of ESI 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 offers no significant long-term functional benefit. 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. In this case, the claimant had equivocal exam findings for radiculopathy. MRI did not mention cord impingement. The ACOEM guidelines do not recommend invasive procedures such as ESI due to their short term benefit. The request for an S1 ESI is not medically necessary.

Transforaminal epidural steroid injection: Bilateral C5 x1: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines in Workers Compensation, Epidural Steroid Injections.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines epidural injections Page(s): 47.

Decision rationale: According to the guidelines, the criteria for the use of Epidural steroid injections: Note: The purpose of ESI 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 offers no significant long-term functional benefit. 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. In this case, the claimant had an EMG which indicated carpal tunnel without cervical involvement. The physical findings were not consistent with radicular signs. The request for a C5 ESI is not medically necessary.