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| Case Number: | CM15-0185683 | | |
| Date Assigned: | 09/25/2015 | Date of Injury: | 04/24/2014 |
| Decision Date: | 11/06/2015 | UR Denial Date: | 09/16/2015 |
| Priority: | Standard | Application Received: | 09/21/2015 |

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: Massachusetts

Certification(s)/Specialty: Anesthesiology, Pain Management

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 female who sustained an industrial injury on April 24, 2014. At a spine follow up dated September 02, 2015 chief subjective complaint was: low back and leg pain. Current medication regimen consisted of: Lyrica, Ultracet, and Relafen. The worker is rating pain 6 out of 10 in intensity with diagram showing low back and buttock pain bilaterally. In addition, there is a "radiating sensation of pain and numbness in the posterior lateral aspect of the left leg." Activity modifications and medications improve the symptoms. Medications are limited secondary to sensitivity to sedation and cognitive effects. The plan of care is with requested recommendation for bilateral L5-S1 transforaminal epidural injections secondary to positive magnetic resonance results, decreased strength and sensation, and positive neural tension. A recent physical therapy note dated July 16, 2015 reported subjective findings of: "states her low back pain has improved since initiating physical therapy." However, "she does continue to experience significant symptoms of burning and sharp pain at her left buttock, radiating down to her left leg and foot." She experienced "minimal change in lower extremity symptoms with physical therapy." She states: "injections with denial". She also reports "severe limitations with activities such as sleeping and lifting, and avoids traveling due to lower extremity pain." Primary follow up dated August 18, 2015 reported she was taken off from work due to severe persistent leg and low back symptom, and given Medrol which "did result in improvement but limited to 1-2 weeks." Pain has slowly returned. She also utilizes a transcutaneous nerve stimulator unit. A Standing request for bilateral transforaminal epidural injections remains plan of care. On September 09, 2015 a request was made for bilateral transforaminal epidural injections at L5-S1 which noted with non-certification from Utilization review on September 16, 2015. Of note, documentation reported on January 08, 2015 the most recent administration of bilateral transforaminal epidural injection without issue.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral L5-S1 TFESI Under moderate sedation with fluoroscopic guidance epidurography Qty 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

Decision rationale: Accordingly to the MTUS, epidural steroid injections are recommended as an option for treatment of radicular pain (defined as pain in dermatome distribution with corroborative findings of radiculopathy). See specific criteria for use below. Most current guidelines recommend no more than 2 ESI injections. This is in contradiction to previous generally cited recommendations for a series of three ESIs. These early recommendations were primarily based on anecdotal evidence. Research has now shown that, on average, less than two injections are required for a successful ESI outcome. Current recommendations suggest a second epidural injection if partial success is produced with the first injection, and a third ESI is rarely recommended. 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 is little information on improved function. The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months, and there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain. (Armon, 2007) See also Epidural steroid injections, series of three. 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. According to the documents available for review, the IW previously underwent an epidural injection with less than 50% relief for 4 weeks, The IW does not meet the requirements above for repeat injection therapy required by the MTUS above. Therefore, at this time, the requirements for treatment have not been met and medical necessity has not been established.