

Case Number:	CM15-0191828		
Date Assigned:	10/05/2015	Date of Injury:	12/15/1991
Decision Date:	11/19/2015	UR Denial Date:	09/03/2015
Priority:	Standard	Application Received:	09/29/2015

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: California, District of Columbia, Maryland
 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:

This 57 year old female sustained an industrial injury on 12-30-91. Documentation indicated that the injured worker was receiving treatment for lumbar spondylosis, lumbar facet syndrome and chronic pain syndrome. Previous treatment included facet joint injection, radiofrequency ablation, trigger point injections, home exercise and medications. In a PR-2 dated 5-13-15, the injured worker complained of bilateral low back and hip pain as well as neck pain associated with numbness, tingling and weakness. The injured worker rated her worst pain 10 out of 10 on the visual analog scale and least pain 2 out of 10. The physician noted that he had not treated this patient in the past 3 years. The physician stated that the injured worker's pain was exacerbated by extension and rotation and was associated with rigidity. The physician suspected that facet joints were the origin of pain. The injured worker reported that past medial branch blocks resulted in elimination or marked decrease in the intensity of pain. On 7-14-15, the injured worker radiofrequency ablation at bilateral L4-5 and L5-S1. In an office visit dated 8-20-15, the injured worker complained of right low back and hip pain with radiation to the legs and neck pain with radiation to the arm and shoulder, associated with muscle spasms, numbness, tingling and weakness. The injured worker reported minimal response to recent trigger point injections. The injured worker rated her pain 6 to 10 out of 10. The injured worker reported visiting the Emergency Department on 8-18-15 due to pain. Physical exam was remarkable for lumbar spine with tenderness to palpation at L4-5 and L5-S1 and bilateral sacroiliac notches with spasms, positive bilateral straight leg raise, positive right Patrick's maneuver, pain reproduced on facet loading maneuvers, diminished bilateral lower extremity strength and intact sensation to

light touch to bilateral lower extremities. The injured worker reported that she had had epidural steroid injections and facet joint injections in the past, which helped with the pain. The treatment plan included continuing home exercise, continuing medications (Baclofen, Oxycodone, Voltaren gel and Gabapentin), obtaining a lumbar magnetic resonance imaging and requesting authorization for caudal epidural steroid injections. On 9-3-15, Utilization Review noncertified the request for caudal epidural steroid injection.

IMR ISSUES, DECISIONS AND RATIONALES

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

Caudal Epidural Steroid Injection: 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: Per the MTUS CPMTG epidural steroid injections are used 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 benefit. The criteria for the use of epidural steroid injections are as follows: 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. Per the documentation submitted for review, bilateral lower extremity weakness was noted. Sensation to pin prick was intact. Reflexes were 2+ in all muscle groups. MRI of the lumbar spine dated 9/21/15 revealed at L5-S1: "the disc is normal, and the central canal is patent. I see mild hypertrophy of the facets and mild to moderate narrowing of the foramina." Above-mentioned citation conveys radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Radiculopathy is defined as two of the following: weakness, sensation deficit, or diminished/absent reflexes associated with the relevant dermatome. These findings are not documented, so medical necessity is not affirmed. As the first criterion is not met, the request is not medically necessary.