

Case Number:	CM15-0199880		
Date Assigned:	10/15/2015	Date of Injury:	11/12/2013
Decision Date:	11/30/2015	UR Denial Date:	09/09/2015
Priority:	Standard	Application Received:	10/12/2015

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: New York, Tennessee

Certification(s)/Specialty: Emergency Medicine

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 50 year old male who sustained an industrial injury November 12, 2013. Past history included status post ACDF (anterior cervical discectomy and fusion) C4-5 August 1994, ORIF (open reduction internal fixation) right tibia-fibula with revision, left ankle fusion August 1994, and bilateral carpal tunnel syndrome, left greater than right, left median nerve block wrist April 22, 2015. Diagnoses are cervical spondylosis without myelopathy; cervical disc degeneration; lumbar radiculopathy; cervical radiculopathy; degenerative disc disease. According to a primary treating physician's progress report dated August 12, 2015, the injured worker presented with complaints of chronic back pain described as; cervical, thoracic and lumbar pain and reports having the symptoms for (638) days, with numbness and tingling of the lower extremities along the lateral left leg. He reported the symptoms are exacerbated by walking and lessened by physical therapy, pain medication and biking. He also reported neck and upper back pain and insomnia and anxiety, all for (638) days. He rated his overall pain 7 out of 10. The treating physician documented the injured worker had epidural injection to the neck with significant improvement (not dated); relieving symptoms around the neck and shoulder but symptoms of carpal tunnel syndrome both hands were not affected. He is currently undergoing physical therapy for the neck and low back. Objective findings included; 6'4" and 275 pounds; ambulates with a normal gait, full weight bearing both extremities; Patrick-Fabere test is negative; extensor hallucis longus test is negative; no restriction of range of motion of the back; straight leg raise is negative. At issue, is a request for authorization for an epidural steroid

injection (ESI) left L5-S1. According to utilization review dated September 9, 2015, the request for left L5-S1 epidural steroid injection is non-certified.

IMR ISSUES, DECISIONS AND RATIONALES

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

Epidural steroid injection (ESI) left L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), http://www.odg-twc.com/odgtwc/low_back.htm.

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

Decision rationale: Epidural steroid injections are recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 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. 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, 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. 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. 9) Epidural steroid injection is not to be performed on the same day as trigger point injection, sacroiliac joint injection, facet joint injection or medial branch block. In this case the physical examination is not consistent with the presence of radiculopathy and there is no corroboration with imaging or electrodiagnostic studies. Criteria for epidural steroid injection have not been met. The request is not medically necessary.

