

Case Number:	CM15-0201986		
Date Assigned:	10/16/2015	Date of Injury:	01/30/2002
Decision Date:	12/02/2015	UR Denial Date:	10/06/2015
Priority:	Standard	Application Received:	10/14/2015

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:

The injured worker is a 57-year-old male who sustained an industrial injury on 1-30-2002 and has been treated for low back pain. Diagnostic MRI dated 10-29-2014 supported diagnoses including degenerative disc disease and facet arthropathy without nerve root impingement, and spinal stenosis of lumbar region without neurogenic claudication. The physician's note also provides diagnosis of thoracic-lumbosacral neuritis-radiculitis, unspecified. On 9-16-2015 the injured worker reported low back pain radiating to both hips and buttocks, rated as 8 out of 10, with muscle cramping. Pain was reported as being made worse by activity and prolonged standing and repetitive movements. The examination noted non-antalgic gait, "normal" lumbar range of motion. Documented treatment includes Toradol injection and medications. While "diagnostic injections" are referenced, there is no documentation of previous epidural steroid injections in the provided medical records, or discussion of other therapies. The treating physician's plan of care includes request for authorization dated 9-22-2015 for lumbar spine epidural steroid injection at L5-S1, which was denied on 10-6-2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar epidural steroid injection at L5-S1: Upheld

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

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 progress report dated 9/18/15, physical exam noted sensation was intact to light touch and demarcation between dull and sharp in dermatomes L2-S2 in the bilateral lower extremities. Reflexes in the patella were 1 on the right and 2 on the left. Achilles reflexes were 1 on the right and 2 on the left. Muscle strength for the quadriceps was 5/5 bilaterally, hamstring strength was 5/5 bilaterally, gastrocnemius strength was 5/5 bilaterally, and tibialis anterior muscle strength was 5/5 bilaterally. MRI of the lumbar spine dated 10/29/14 revealed mild degenerative disc disease and facet arthropathy of the lower lumbar spine, without definitive nerve root impingement. There was no significant spinal stenosis. 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. The injured worker does not meet the definition of radiculopathy, and as there is no imaging study corroborating radiculopathy, the request is not medically necessary.