

Case Number:	CM15-0208287		
Date Assigned:	10/27/2015	Date of Injury:	02/29/2008
Decision Date:	12/08/2015	UR Denial Date:	10/12/2015
Priority:	Standard	Application Received:	10/22/2015

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: Physical Medicine & Rehabilitation, 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 62-year-old male who sustained an industrial injury on 2-29-2008 and has been treated for cervicgia and lumbar and cervical disc disorders. On 8-12-2015 the injured worker reported that lumbar pain was constant and rated it as 5 out of 10, with the physician stating this as "unchanged." Pain was described as sharp and radiating down both legs, aggravated by bending, lifting, twisting, pushing, pulling, walking several blocks, and prolonged positioning. Objective examination noted palpable paravertebral muscle tenderness including spasm, positive seated nerve root test, and guarded, restricted flexion and extension while standing. Documented treatment includes acupuncture, medication, and a transforaminal lumbar epidural steroid injection 6-8-2015. Results were not provided. A letter dated 6-8-2015 which was the day of the last injection, states the injured worker required anesthesia due to "severe anxiety" associated with steroid injections. The treating physician's plan of care includes a Lumbar epidural steroid injection at L5-S1 with monitored anesthesia care which was modified to be without monitored anesthesia on 10-12-2015.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar epidural steroid injection (ESI) at L5-S1 (sacroiliac), Qty 1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs). Decision based on Non-MTUS Citation Official Disability Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back-Lumbar & Thoracic (Acute & Chronic) Epidural steroid injections (ESIs), therapeutic.

Decision rationale: The claimant sustained a work injury in February 2008 and continues to be treated for radiating neck and radiating low back pain. An MRI of the lumbar spine is referenced as showing an L4/5 disc protrusion with left lateralized foraminal narrowing. On 06/03/15 he had constant low back pain with lower extremity radiating symptoms on the left greater than right side with pain rated at 7/10. A lumbar epidural steroid injection was pending. A letter of medical necessity in June 2015 references the claimant as having researched epidural injections. He was concerned about moving during the procedure if local anesthetic was used. He believed that if local anesthetic was used and there was even slight movement there was the possibility of paralysis. Anesthesia was requested as this was the only way the claimant would agree to the procedure. The injection was performed on 06/08/15. A left L4/5 transforaminal epidural injection was done with sedation. He underwent a cervical epidural injection on 06/22/15. On 07/01/15 he had pain rated at 5/10. On 08/12/10 his pain was unchanged. When seen, physical examination findings included positive left straight leg raising and abnormal left lower extremity sensation. A more than 60% response from the previous injection is referenced lasting for more than three months. The claimant has hypertension, hyperlipidemia, and a body mass index of nearly 30. In the therapeutic phase guidelines recommend that a repeat epidural steroid injection 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. In this case, the claimant is reported to have had a 60% response to the first injection and therefore a therapeutic injection is being requested. However, this degree of pain relief is not substantiated by the records provided for review which show a decreased in pain of less than 30%. A repeat lumbar epidural steroid injection is not medically necessary.

Monitored anesthesia care, [for Lumbar epidural steroid injection (ESI) at L5-S1 (sacroiliac), Qty 1]: Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines-Conscious sedation.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back-Lumbar & Thoracic (Acute & Chronic) Epidural steroid injections (ESIs), therapeutic.

Decision rationale: The claimant sustained a work injury in February 2008 and continues to be treated for radiating neck and radiating low back pain. An MRI of the lumbar spine is referenced as showing an L4/5 disc protrusion with left lateralized foraminal narrowing. On 06/03/15 he had constant low back pain with lower extremity radiating symptoms on the left greater than right

side with pain rated at 7/10. A lumbar epidural steroid injection was pending. A letter of medical necessity in June 2015 references the claimant as having researched epidural injections. He was concerned about moving during the procedure if local anesthetic was used. He believed that if local anesthetic was used and there was even slight movement there was the possibility of paralysis. Anesthesia was requested as this was the only way the claimant would agree to the procedure. The injection was performed on 06/08/15. A left L4/5 transforaminal epidural injection was done with sedation. He underwent a cervical epidural injection on 06/22/15. On 07/01/15 he had pain rated at 5/10. On 08/12/10 his pain was unchanged. When seen, physical examination findings included positive left straight leg raising and abnormal left lower extremity sensation. A more than 60% response from the previous injection is referenced lasting for more than three months. The claimant has hypertension, hyperlipidemia, and a body mass index of nearly 30. In terms of monitored anesthesia, the risk of paralysis due to inadvertent movement using a transforaminal approach in the lumbar spine would be extremely low and the claimant has medical conditions and is obese which would increase the risk of using monitored anesthesia. Educating the claimant about the relative benefits of monitored anesthesia care versus the risks of anesthesia would be the expected management. Additionally, the repeat lumbar epidural steroid injection is not medically necessary. Therefore, the request for monitored anesthesia care is also not medically necessary.