

Case Number:	CM15-0209491		
Date Assigned:	10/28/2015	Date of Injury:	07/23/2015
Decision Date:	12/08/2015	UR Denial Date:	10/16/2015
Priority:	Standard	Application Received:	10/23/2015

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, Oregon, Washington
 Certification(s)/Specialty: Orthopedic Surgery

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 34 year old male who sustained an industrial injury on 07-23-2015. MRI of the lumbar spine performed on 08-27-2015 showed moderate degenerative disc disease at L4-5 and L5-S1, mild to moderate bilateral foraminal narrowing at L5-S1 and mild left neuroforaminal narrowing at L3-4. According to a progress report dated 09-29-2015, the injured worker reported low back pain. Intensity of pain was rated 7-10 out of 10 and radiated to the bilateral lower extremities left greater than right. There was also some weakness in the right with numbness and tingling right greater than left. Pain was increased with sitting, walking and laying down. Medications included Hydrocodone-APAP, Tramadol and Methocarbamol. Straight leg raise was positive bilaterally. Toe and heel walking were decreased due to pain. Assessment included radiculopathy, spondylosis lumbar, degenerative disc disease lumbar, and stenosis lumbar and herniated disc lumbar. The treatment plan included "started" Tramadol, Tizanidine and Naproxen Sodium and x-ray of the lumbosacral spine. An authorization request dated 10-12-2015 was submitted for review. The requested services included left L5-S1, L4-5 epidural steroid injection with sedation under fluoroscopy; physical medicine & rehabilitation consult. On 10-16-2015, Utilization Review non-certified the request for outpatient left L5-S1 and L4-L5 epidural steroid injection with sedation under fluoroscopy with physical medicine and rehabilitation specialist.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient left L5-S1 and L4-L5 epidural steroid injection with sedation under fluoroscopy with physical medicine and rehabilitation specialist: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004. Decision based on Non-MTUS Citation Official Disability Guidelines.

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

Decision rationale: According to the CA MTUS Chronic Pain Medical Treatment Guidelines, Epidural injections, page 46, "Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy)." Specifically the guidelines state that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 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. 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. In addition there must be demonstration of unresponsiveness to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). CA MTUS criteria for epidural steroid injections are: "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." In this case the exam notes from 9/29/15 do not demonstrate a failure of conservative management nor a clear evidence of a dermatomal distribution of radiculopathy. Per CA MTUS guidelines, no more than one interlaminar level should be injected at one session. Therefore the request is not medically necessary.