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| Case Number: | CM15-0209660 | | |
| Date Assigned: | 10/28/2015 | Date of Injury: | 11/02/2010 |
| Decision Date: | 12/15/2015 | UR Denial Date: | 10/23/2015 |
| Priority: | Standard | Application Received: | 10/26/2015 |

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 32 -year-old female who sustained an industrial injury on 11-2-2010 and has been treated for low back pain. Diagnostic MRI is noted to have shown degenerative disc and collapsed disc with no evidence of stenosis centrally or foraminally at L3-L5. Diagnoses are left sacroiliitis and lumbar spine sprain and strain. On 10-5-2015, the injured worker reported pain over the SI joint area without radiating symptoms. Characterization or pain level was not provided. Objective findings included no paraspinal tenderness to the musculature or spinous processes, no spasm, and no palpable abnormalities. Range of motion included flexion 40 degrees, extension 5 degrees, right and left lateral bends 10, and right and left rotation 5 degrees. FABER test was positive on the left side as was left SI joint shear and compression tests. Documented treatment includes physical therapy; epidural injection of the lumbar spine without description of response, date of injection; acupuncture; medication; and physical therapy "without much help." In the 10-5-2015 note, the physician stated that "she has already tried significant amount of different treatments without any kind of improvement." The request was submitted for a lumbar epidural with sedation, which was non-certified on 10-23-2015. The injured worker was noted to have been out of work and disabled.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar epidural with sedation: 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 9/14/15, it was noted per neurological exam "There is no evidence of a radiculopathy, myelopathy, or peripheral nerve motor or sensory deficits. Sensation to light touch and proprioception is intact throughout all dermatomal distributions. Deep tendon reflexes of the quadriceps, Achilles, biceps, triceps, and brachioradialis are 2+ and equal bilaterally." MRI (date unknown) showed disc bulges at L3-L4 and L4-L5. 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 criteria is not met, the request is not medically necessary. Furthermore, there no documentation indicating that the injured worker suffers from anxiety, which would necessitate sedation. Therefore, the request is not medically necessary.