MAXIMUS Federal Services

Case Number:	CM15-0214504		
Date Assigned:	11/04/2015	Date of Injury:	10/20/2007
Decision Date:	12/18/2015	UR Denial Date:	10/05/2015
Priority:	Standard	Application Received:	10/30/2015

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: Iowa, Illinois, California
Certification(s)/Specialty: Preventive Medicine, Occupational Medicine, Public Health & General Preventive 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 55-year-old female who sustained an industrial injury on 10-20-07. Medical records indicate that the injured worker has been treated for lumbosacral disc degeneration; lumbosacral neuritis; low back pain; facet syndrome, lumbar spine; lumbar post laminectomy syndrome. She currently (8-29-15) complains of constant low back pain radiating down bilateral legs that was exacerbated about 1 month ago when she bent down. She has a pain level of 10 out of 10. The pain affects her sleep, activities of daily living and work. The physical exam revealed limited range of motion of the lumbar spine, positive straight leg raise bilaterally, positive facet loading maneuvers bilaterally, difficulty with twisting and bending due to pain and she walks gingerly per documentation. Imaging studies (no date given) demonstrate posterior rod and screws at L5-S1 with anterior plate; spinal cord stimulator in the thoracic level; adjacent disease at L4-5 with loss of disc height. Treatments to date include medication: ibuprofen, Lyrica: prior medication: Lexapro, Ambien; spinal cord stimulator implanted in 2008, which she does not use because of poor results; status post back fusion (2007 and 2012). Indication of prior transforaminal epidural steroid injections was not present. The request for authorization was not present. On 10-5-15 Utilization Review non-certified the request for transforaminal epidural steroid injection to L4-5 level.

IMR ISSUES, DECISIONS AND RATIONALES

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

Transforaminal epidural steroid injection at L4-L5 level: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004, and Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

MAXIMUS guideline: Decision based on MTUS Low Back Complaints 2004, Section(s): Physical Methods, and Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs). Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Epidural steroid injections (ESIs), therapeutic.

Decision rationale: MTUS Chronic pain medical treatment guidelines state that epidural steroid injections are "Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) . . . 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." ACOEM states, "Invasive techniques (e.g., local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit. Although epidural steroid injections may afford short-term improvement in leg pain and sensory deficits in patients with nerve root compression due to a herniated nucleus pulposus, this treatment offers no significant long-term functional benefit, nor does it reduce the need for surgery. Despite the fact that proof is still lacking, many pain physicians believe that diagnostic and/or therapeutic injections may have benefit in patients presenting in the transitional phase between acute and chronic pain." MTUS further defines the criteria for epidural steroid injections to include: 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"series-of-three" injections in either the diagnostic or the therapeutic phase. We recommend no more than 2 ESI injections. In the documentation provided, the treating physician indicates this patient had "good results" from the previous ESI. However, the medical documentation provided for review does not include documentation of objective functional improvement and at least 50% pain relief with associated reduction of medications for six to eight weeks as outlined in the guidelines above. As such, the request for Transforaminal epidural steroid injection at L4-L5 level is not medically necessary.