

Case Number:	CM15-0219455		
Date Assigned:	11/12/2015	Date of Injury:	10/19/1998
Decision Date:	12/30/2015	UR Denial Date:	10/20/2015
Priority:	Standard	Application Received:	11/09/2015

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

Certification(s)/Specialty: Emergency 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 65 year old female, who sustained an industrial injury on 10-19-1998. According to physician documentation, the injured worker was diagnosed with lumbago and thoracic lumbosacral radiculitis/neuritis. Subjective findings dated 10-12-2015, were notable for continued low back pain that vibrates down legs making it difficult to walk and get up and down, rating pain as 5-6 out of 10. Objective findings dated 6-23-2015, were notable for lumbar spine tenderness on palpation, diffusely in the upper extremity, weakness of great toe on extension and pain in the lumbar spine that follows L4-L5 (lumbar) and L5-S1 (sacral) and significant weakness of the lower extremities. Physician note dated 10-15-2015, were notable for her back being non-tender over the cervical spine and paraspinous, non-tender over thoracic spine and paraspinous muscles, with diffuse tenderness on palpation of the lumbar spine, mid upper portion, lower portion, right and left S1 joints with straight leg raise to 30 degrees secondary to pain. An MRI of the lumbar spine was performed on 8-2-2011, revealing lateral recess disc protrusion and a slight disc bulge at L4-L5 level with mild bilateral neural foraminal. Treatments to date have included Lyrica 50mg (since 8-12-2015), Advil 200mg (since 9-30-2013), Duragesic patch 100mcg (since 11-18-2014), Duragesic patch 12mcg (since 9-8-2014), steroid injections and back surgery. The Utilization Review determination dated 10-20-2015 did not certify retrospective treatment/service requested for transforaminal epidural steroid injection right L4-L5.

IMR ISSUES, DECISIONS AND RATIONALES

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

Transforaminal Epidural Steroid Injection Right L4-L5: 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 Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

Decision rationale: The request is for epidural steroid injections, which is an injection of a corticosteroid into the epidural space, typically used in the lumbar spine to treat chronic low back pain. It is recommended as an option for treatment of radicular pain. 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. 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. There is little information on improved function. 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, and there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain. Criteria for the use of epidural steroid injections 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. 8) Current research does not support a "series-of-three" injections in either the diagnostic or therapeutic phase. The MTUS guidelines recommends no more than 2 ESI injections. In regards to the injured, there is documentation of a positive response to previous epidural steroid injection, with an overall reduction of pain of "60-70% lasting greater than 4 months." However, documentation stated "previous procedures have included epidural steroid injections." As stated previously the MTUS guidelines does not support more than 2 ESI injections over a lifetime for the treatment of the same chronic pain, as there is little data to support such use. With documentation of a plural number of previous procedures, repeat epidural steroid injection cannot be supported without documentation from the treating physician that clearly addresses this issue. The request as submitted is not supported by the MTUS guidelines and therefore is not medically necessary.