

Case Number:	CM15-0220629		
Date Assigned:	11/13/2015	Date of Injury:	09/10/2014
Decision Date:	12/23/2015	UR Denial Date:	11/04/2015
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: Arizona, California

Certification(s)/Specialty: Family Practice

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 51 year old male who sustained an industrial injury on 09-10-2014. Medical records indicated the worker was treated for thoracic sprain and strain and lumbar sprain and strain. In the provider notes of 10-23-2015, the injured worker complains of low back pain and pain in the right lower extremity rated a 4 on a scale of 0-10 and reported weakness of the right shoulder, right hip and bilateral knees that was aggravated by driving, turning head, lying down, coughing and sneezing, and alleviated by medication. Prior treatments have included right knee surgery, left shoulder surgery, physical therapy, home exercise, and medications (Tramadol and hydrocodone were prescribed for his knee). Symptoms also decrease with Valsalva maneuvers. On exam, the worker can flex forward about 30 degrees and complains of pain in the low back. Hyperextension to 20 degrees causes low back pain, and right flexion causes low back pain but left flexion does not cause low back pain. Faber's test was positive for sacroiliac joint pain and thigh thrust was positive. Right side iliac wing compression was positive for sacroiliac joint pain and both sacroiliac joints were tender to palpation. There was tenderness in the sciatic notch, tenderness to palpation over the lower lumbar facets. A MRI of the lumbar spine from 03-18-2015 revealed posterior disc protrusion at L5-S1. The treatment plan included lumbar injections under intravenous sedation and fluoroscopy. A request for authorization was submitted for Lumbar injections under IV sedation and fluoroscopy A utilization review decision 11-04-2015 non-certified the request.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar injections under IV sedation and fluoroscopy: Upheld

Claims Administrator guideline: Decision based on MTUS Low Back Complaints 2004, and Chronic Pain Medical Treatment 2009.

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

Decision rationale: According to the guidelines, the 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. 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. According to the guidelines, ESI s are indicated for those with radiculopathy on exam and imaging. In this case, the imaging report was not provided. The physician note indicated that there is lumbar disc herniation but no mention of nerve root encroachment. In addition the ACOEM guidelines do not recommend ESI due to their short term benefit. As a result, the request for lumbar injections is not medically necessary.