

Case Number:	CM15-0224754		
Date Assigned:	11/23/2015	Date of Injury:	10/20/2014
Decision Date:	12/31/2015	UR Denial Date:	10/27/2015
Priority:	Standard	Application Received:	11/16/2015

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 35 year old female, who sustained an industrial injury on 10-20-14. The injured worker was being treated for cervical disc displacement, cervical disc disorder with radiculopathy, spondylosis with radiculopathy of lumbar region, intervertebral disc disorders with radiculopathy of lumbar region, pain in left shoulder and bursitis of hip. On 10-12-15, the injured worker complains of increased neck pain with radiation down left arm, episodes of left upper extremity numbness and moderate low back pain with radiation down the right lower extremity. Work status on 5-27-15 was noted to be full duty. Physical exam performed on 10-12-15 revealed tenderness to cervical spinous process, tenderness over the trapezius muscle with decreased sensation of left shoulder region and restricted range of cervical motion; and lumbar exam revealed slow and careful gait, stiff range of motion, significant muscle spasms with decreased sensation along right lateral calf, pain in right greater trochanter area and pain with range of motion of hips. MRI of lumbar spine performed on 7-20-15 revealed annular high intensity zone in left neural foramen at L4-5 with extension of disc material into both foramen and also at L4-5 facet arthropathy along with broad based disc posterior disc bulge at L5-S1 with mild to moderate facet arthropathy. Treatment to date has included oral medication including Percocet, Pamelor and Cymbalta; topical Voltaren gel, physical therapy and activity modifications. On 10-20-15 request for authorization was submitted for lumbar epidural steroid injection at L4-5. The treatment plan included request for epidural steroid injection of lumbar spine. On 10-27-15 request for epidural steroid injection of lumbar spine was non-certified by utilization review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Lumbar epidural steroid injection (LESI) at L4-5: 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: 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 10/12/15 do not demonstrate a failure of conservative management nor a clear evidence of

a dermatomal distribution of radiculopathy. Therefore the proposed epidural steroid injection is not medically necessary.