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| Case Number: | CM14-0214518 | | |
| Date Assigned: | 01/07/2015 | Date of Injury: | 05/06/2010 |
| Decision Date: | 02/24/2015 | UR Denial Date: | 11/26/2014 |
| Priority: | Standard | Application Received: | 12/22/2014 |

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: New Jersey
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 worker is a 70 year old male who was injured on 5/6/10. He was diagnosed with lumbago, lumbar sprain, lumbar disc herniation, thoracic sprain, myalgia/myositis, and rotator cuff sprain. He was treated with epidural injection (11/2012), which lasted for one month. He was also treated with a walker, medications, TENS, heat, and home exercises/physical therapy. On 10/30/14, the worker was seen by his neurosurgeon, reporting continual low back pain, rated 8/10 on the pan scale, which radiates to the left leg/foot and associated with numbness, tingling, swelling, cramps, and weakness. Physical findings included limited range of motion and dependence on walker for ambulation. No neurologic examination findings were included in the note. The worker was then recommended home exercises, an updated lumbar spine MRI, an L5-S1 epidural injection, and to follow-up with the new studies.

IMR ISSUES, DECISIONS AND RATIONALES

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

Repeat L5-S1 epidural steroid injection: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG)- Low back, MRIs

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections Page(s): 46.

Decision rationale: The MTUS Guidelines state that epidural steroid injections are recommended as an option for treatment of lumbar radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) and can offer short term pain relief, but use should be in conjunction with other rehab efforts, including continuing a home exercise program. The criteria as stated in the MTUS Guidelines for epidural steroid injection use for chronic pain includes the following: 1. Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing, 2. Initially unresponsive to conservative treatment (exercise, physical methods, NSAIDs, and muscle relaxants), 3. Injections should be performed using fluoroscopy 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, and 8. Current research does not support a series-of-three injections in either the diagnostic or therapeutic phase and instead only up to 2 injections are recommended. In the case of this worker, there was some evidence of radiculopathy based on subjective complaints found in the progress note, however, the neurosurgeon failed to document any neurologic findings which might have helped back up the need for an epidural injection. Regardless, however, the first lumbar epidural injection produced reported one month duration of benefit, rather than the required 6-8 weeks or more duration, and no report was found with the level of pain after the first injection. Therefore, considering the above reasons, the epidural steroid injection of the lumbar spine will be considered medically unnecessary and will not likely improve the long-term outcome.

MRI for the lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines- Treatment in Worker's Compensation, Online Edition, Low Back, MRI's(Magnetic Resonance Imaging)

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 296-310.

Decision rationale: MTUS Guidelines for diagnostic considerations related to lower back pain or injury require that for MRI to be warranted there needs to be unequivocal objective clinical findings that identify specific nerve compromise on the neurological examination (such as sciatica) in situations where red flag diagnoses (cauda equina, infection, fracture, tumor, dissecting/ruptured aneurysm, etc.) are being considered, and only in those patients who would consider surgery as an option. In some situations where the patient has had prior surgery on the

back, MRI may also be considered. The MTUS also states that if the straight-leg-raising test on examination is positive (if done correctly) it can be helpful at identifying irritation of lumbar nerve roots, but is subjective and can be confusing when the patient is having generalized pain that is increased by raising the leg. The Official Disability Guidelines (ODG) state that for uncomplicated low back pain with radiculopathy MRI is not recommended until after at least one month of conservative therapy and sooner if severe or progressive neurologic deficit is present. The ODG also states that repeat MRI should not be routinely recommended, and should only be reserved for significant changes in symptoms and/or findings suggestive of significant pathology. The worker in this case was having similar complaints as previous office visits as seen in the documentation provided for review. There was no evidence of any red flag diagnoses. Also, the neurosurgeon failed to document any neurologic findings which might have helped justify a repeat MRI. Therefore, considering the above reasons, the MRI of the lumbar spine will be considered medically unnecessary.