

Case Number:	CM15-0016668		
Date Assigned:	02/05/2015	Date of Injury:	02/16/2007
Decision Date:	03/26/2015	UR Denial Date:	01/23/2015
Priority:	Standard	Application Received:	01/29/2015

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: Virginia
 Certification(s)/Specialty: Neurology

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 47 year old male who sustained an industrial injury reported on 2/16/2007 when he fell off a ladder . He has reported neck and left arm pain, with increased low back pain, and severe left sciatica type pain. He complains of low back pain that radiates into his left leg with a pain intensity of 7-8/10. On latest physical exam, the injured worker was noted to have 5-/5 strength throughout bilateral lower extremities likely due to pain. There is decreased sensation to pin prick in the left leg in an L5 dermatomal pattern. The diagnoses have included carpal tunnel syndrome; chronic pain due to trauma; degeneration of lumbar or lumbosacral intervertebral disc. There is an MRI L spine dated 21 July, 2008 which showed mild disk bulges at the L4-L5 and L5-S1 levels but without evidence of central canal stenosis or of nerve root compression. Treatments to date have included consultations; diagnostic imaging studies; Toradol injection therapy; lumbar epidural steroid injection therapy; and medication management. The work status classification for this injured worker (IW) was noted to be back to be unable to return to work since the injury. On 1/23/2015, Utilization Review (UR) non-certified, for medical necessity, the request, made on 1/19/2015, for lumbar 5 - sacral 1 transforaminal epidural steroid injection with fluoroscopic guidance and conscious sedation. The Medical Treatment Utilization Schedule, chronic pain medical treatment guidelines, lumbar epidural steroid injection; and the Official Disability Guidelines, chronic pain chapter, epidural steroid injection, were cited.

IMR ISSUES, DECISIONS AND RATIONALES

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

Outpatient L5-S1 transforaminal epidural steroid injection with flouroscopic guidance and concious sedation: Upheld

Claims Administrator guideline: The Claims Administrator did not cite any medical evidence for its decision.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Section: Epidural Steroid Injections Page(s): 46.

Decision rationale: Chronic pain medical treatment guidelines recommend epidural steroid injections for the treatment of radicular pain defined as pain in a dermatomal distribution with corroborative findings of radiculopathy. The purpose of epidural steroid injections is to reduce pain and inflammation, restoring range of motion and thereby facilitating progress and more active treatment programs, and avoiding surgery, but this treatment alone offers no significant long-term functional benefits. Specific criteria for the use of epidural steroid injections includes the finding that the radiculopathy must be documented by physical examination and corroborated by imaging studies and or electrodiagnostic testing. The condition must initially be unresponsive to conservative treatment with exercises, physical methods, and medications. In the therapeutic phase, repeat blocks should be based on continued objective documentation of decreased pain and functional improvements, including at least 50% pain relief with associated reduction of medication for 6-8 weeks. The epidural steroid injection, short-term pain relief but should be used in conjunction with other rehabilitation efforts including a home exercise program. In the case of the injured worker described above, there is no specific documentation that the patient's symptoms in the back and leg are specifically do to her radiculopathy. There is no clinical corroboration of the patient's symptoms with specific MRI findings of her radiculopathy. There is no documentation of electrodiagnostic testing to clarify a diagnosis of her radiculopathy. There is no specific documentation of a clinical treatment plan with conservative treatment nor is there documentation of a home exercise program. Therefore, according to the guidelines and a review of the evidence, a request for an outpatient L5-S1 transforaminal epidural steroid injection with fluoroscopic guidance and conscious sedation is not medically necessary.