

Case Number:	CM15-0123762		
Date Assigned:	07/08/2015	Date of Injury:	03/11/2011
Decision Date:	08/11/2015	UR Denial Date:	06/17/2015
Priority:	Standard	Application Received:	06/26/2015

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, District of Columbia, Maryland
 Certification(s)/Specialty: Anesthesiology, Pain Management

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 48-year-old female, who sustained an industrial injury on 3/11/2011. Diagnoses include grade I spondylolytic spondylolisthesis L5 and S1 with bilateral foraminal narrowing. Treatment to date has included conservative measures including diagnostics, medications and epidural steroid injections. Per the Primary Treating Physician's Progress Report dated 3/29/2015, the injured worker reported low back pain, bilateral leg pain and bilateral leg numbness and weakness. Physical examination revealed decreased range of motion of the lumbar spine, decreased sensation in the bilateral lower extremities, L4, L5 and S1 distribution and straight leg raise test caused back and buttock pain. Magnetic resonance imaging (MRI) of the lumbar spine was read by the evaluating provider as grade I spondylolytic spondylolisthesis L5 and S1 with bilateral foraminal narrowing. There are also small disc bulges at L2-3, L3-4, and L4-5 with no evidence of central, but mils foraminal narrowing. The plan of care included referral to pain management for possible epidural steroid injections, medications and follow-up care. Authorization was requested for transforaminal epidural steroid injection right L4-5 and L5-S1.

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 and L5-S1: Overturned

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines criteria for the use of epidural steroid injections Page(s): 46.

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

Decision rationale: Per the MTUS CPMTG epidural steroid injections are used 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 benefit. The criteria for the use of epidural steroid injections are as follows: 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electro diagnostic 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. Per progress report dated 5/27/15, bilateral lower extremity weakness as well as sensory deficit was noted. MRI of the lumbar spine dated 3/4/15 revealed at L4-L5 a broad-based disc herniation indenting the thecal sac with concurrent bilateral facet degenerative change causing narrowing of the bilateral neural foramen. At L5-S1 a diffuse disc herniation having a small inferiorly migrated component and with concurrent bilateral facet degenerative change and together with the anterior listhesis of L5 collectively causing stenosis of the spinal canal and narrowing of the bilateral lateral recess and bilateral neural foramen with contact on the bilateral L5 exiting nerve roots. It was noted that the injured worker had previous epidural steroid injection in 2009 with significant pain relief greater than 50% pain reduction for three months. I respectfully disagree with the UR physician's denial based upon a lack of a recent course of conservative intervention; the documentation submitted for review supports the requested procedure. Per progress report dated 4/12/11, it was noted that the injured worker was treated with physical therapy. The request is medically necessary.