

Case Number:	CM15-0126259		
Date Assigned:	07/10/2015	Date of Injury:	07/18/2014
Decision Date:	08/11/2015	UR Denial Date:	06/18/2015
Priority:	Standard	Application Received:	06/30/2015

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

Certification(s)/Specialty: Internal Medicine

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 (n) 36 year old male, who sustained an industrial injury on 7/18/14. He reported pain in his lower back. The injured worker was diagnosed as having lumbago and pain in joint lower leg. Treatment to date has included physical therapy, a lumbar MRI on 3/17/15 showing a disc bulge at L3-L4 and L4-L5, Nabumetone/Relafen, Tramadol/APAP and Ibuprofen. As of the PR2 dated 6/15/15, the injured worker reports low back pain that radiates down into his bilateral lower extremities. Objective findings include an antalgic gait, decreased lumbar range of motion and tenderness to palpation at the lumbosacral junction. The treating physician requested a bilateral transforaminal lumbar epidural steroid injection at L3-L4, and L4-L5, include each level, lumbar epidurogram, IV sedation, fluoroscopic guidance, contrast dye.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 bilateral transforaminal lumbar epidural steroid injection at L3-L4, and L4-L5, include each level, lumbar epidurogram, IV sedation, fluoroscopic guidance, contrast dye:

Overtured

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back Chapter Epidural Steroid Injections.

Decision rationale: Based on ODG guidelines, epidural steroid injections are recommended as a possible option for short-term treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy) with use in conjunction with active rehab efforts. Not recommended for spinal stenosis or for nonspecific low back pain. See specific criteria for use below. Radiculopathy symptoms are generally due to herniated nucleus pulposus or spinal stenosis, but ESIs have not been found to be as beneficial a treatment for the latter condition. Criteria for the use of Epidural steroid injections: Note: The purpose of ESI is to reduce pain and inflammation, thereby facilitating progress in more active treatment programs, reduction of medication use and avoiding surgery, but this treatment alone offers no significant long-term functional benefit. (1) Radiculopathy (due to herniated nucleus pulposus, but not spinal stenosis) must be documented. Objective findings on examination need to be present. Radiculopathy must be corroborated by imaging studies and/or electrodiagnostic testing. (2) Initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs, muscle relaxants & neuropathic drugs). (3) Injections should be performed using fluoroscopy (live x-ray) and injection of contrast for guidance. (4) Diagnostic Phase: At the time of initial use of an ESI (formally referred to as the diagnostic phase as initial injections indicate whether success will be obtained with this treatment intervention), a maximum of one to two injections should be performed. A repeat block is not recommended if there is inadequate response to the first block (< 30% is a standard placebo response). A second block is also not indicated if the first block is accurately placed unless: (a) there is a question of the pain generator; (b) there was possibility of inaccurate placement; or (c) there is evidence of multilevel pathology. In these cases a different level or approach might be proposed. There should be 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 inter-laminar level should be injected at one session. (7) Therapeutic phase: If after the initial block/blocks are given (see Diagnostic Phase above) and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks, additional blocks may be supported. This is generally referred to as the therapeutic phase. Indications for repeat blocks include acute exacerbation of pain, or new onset of radicular symptoms. The general consensus recommendation is for no more than 4 blocks per region per year. (CMS, 2004) (Boswell, 2007) (8) Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response. (9) Current research does not support a routine use of a series-of-three injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections for the initial phase and rarely more than 2 for therapeutic treatment. (10) It is currently not recommended to perform epidural blocks on the same day of treatment as facet blocks or sacroiliac blocks or lumbar sympathetic blocks or trigger point injections as this may lead to improper diagnosis or unnecessary treatment. (11) Cervical and lumbar epidural steroid injection should not be performed on the same day. (Doing both injections on the same day could result in an excessive dose of steroids, which can be dangerous, and not worth the risk for a treatment that has no long-term benefit.) In this case, the patient does have radicular symptoms and they are corroborated by MRI findings. The patient has also failed conservative therapy. Therefore, based on the evidence in this case and the ODG guidelines, the request for 1 bilateral transforaminal lumbar epidural steroid injection at L3-4, and L4 -5, include each level, lumbar epidurogram, IV sedation, fluoroscopic guidance, contrast dye is medically necessary.

