

Case Number:	CM15-0036139		
Date Assigned:	03/04/2015	Date of Injury:	11/14/2011
Decision Date:	05/11/2015	UR Denial Date:	01/23/2015
Priority:	Standard	Application Received:	02/26/2015

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, Washington

Certification(s)/Specialty: Physical Medicine & Rehabilitation, 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 46-year-old male who reported injury on 11/14/2011. The mechanism of injury was the injured worker installs traffic signals and was on a high truck and fell backwards from a height of approximately 6 feet. The injured worker was wearing a helmet but hit his head and lost consciousness for a short period of time. The documentation indicated the injured worker had prior surgery on the lumbar spine and had resultant facet joint disease. The recommendation was for facet injections at L4-5 bilaterally where the laminectomy and facetectomy had created the worst arthrosis. Documentation of 02/03/2015 revealed the injured worker had an MRI of the lumbar spine, which revealed mild to moderate age consistent diffuse degenerative changes and facet arthrosis. There were no acute injuries, pathologic lesions, severe stenosis, or signs of infection. There was a laminectomy defect in the L spine with progressive degenerative disc disease and facet arthropathy. The diagnoses included stenosis cervical and lumbar spine, radiculopathy cervical and lumbar spine, and spondylosis cervical and lumbar spine. The recommendation was to see a physician for selective spinal injections in the neck and back and EMGs of the extremities. Subsequent documentation of 12/29/2014 revealed the injured worker had received multiple lumbar and cervical injections, narcotics, physical therapy, aquatic therapy, land therapy, and a lumbar decompression years ago. The injured worker had tried amitriptyline, Norco, Vicodin, and was noted to be taking sporadic naproxen, Flexeril, and tramadol. The physical examination revealed 5/5 motor strength. The treatment plan included a bilateral L4-5 transforaminal epidural steroid injection with MAC anesthesia.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 bilateral transforaminal epidural steroid injection at L4-5 with sedation: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Physical Therapy; Criteria for use of Epidural Steroid Injections. Decision based on Non-MTUS Citation Official Disability Guidelines: Physical Therapy Guidelines; Lumbar and Thoracic (Acute and Chronic).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injection Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Pain Chapter, Epidural Steroid Injection, Sedation.

Decision rationale: The California Medical Treatment Utilization Schedule Guidelines recommend repeat epidural steroid injections when there is documentation of objective functional improvement, an objective decrease in pain of at least 50%, and documentation of an objective decrease in pain medications for 6 to 8 weeks following injection. They do not, however, address sedation. As such, secondary guidelines were sought. The Official Disability Guidelines indicate that routine use of sedation is not recommended except for injured workers with anxiety. The clinical documentation submitted for review failed to meet the above criteria. The documentation indicated the injured worker had prior injections. However, there was a lack of documentation of objective functional benefit, an objective decrease in pain of 50% or greater, and documentation of a decrease in pain medications for 6 to 8 weeks. There was a lack of documentation indicating the injured worker had extreme anxiety. Given the above, the request for 1 bilateral transforaminal epidural steroid injection at L4-5 with sedation is not medically necessary.