

Case Number:	CM14-0146869		
Date Assigned:	09/12/2014	Date of Injury:	10/29/2007
Decision Date:	10/23/2014	UR Denial Date:	09/04/2014
Priority:	Standard	Application Received:	09/10/2014

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. The expert reviewer is Board Certified in Internal Medicine, has a subspecialty in Rheumatology and is licensed to practice in Maryland. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 56 year old male with date of injury 10/26/2007. The mechanism of injury is not stated in the available medical records. The patient has complained of upper and lower back pain since the date of injury. He has been treated with epidural corticosteroid injections, acupuncture, physical therapy and medications. MRI of the thoracic spine dated 08/2012 revealed mild to moderate sterno-clavicular osteoarthropathy, right greater than left. Objective: decreased and painful range of motion of the thoracic and lumbar spine. Diagnoses: thoracic spine disc disease, lumbar facet syndrome, back pain. Treatment plan and request: epidural steroid injection T7-8 and L4-5, L5-S1.

IMR ISSUES, DECISIONS AND RATIONALES

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

Epidural Steroid Injection thoracic spine T7-T8 and L4-L5, L5-S1 Lumbar spine: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300, Chronic Pain Treatment Guidelines (ESIs). Decision based on Non-MTUS Citation Official Disability Guidelines, Treatment Index, 12th Edition(web), 2014, Low Back

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

Decision rationale: Per the MTUS Chronic Pain Guidelines cited above, the following criteria must be met for an epidural steroid injection to be considered medically necessary: "1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic 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." The available medical records do not include documentation that meets criteria (1) and (7) above. Specifically, radiculopathy was not documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing and there is no provided objective documentation that pain and functional improvement were improved by previous injection. On the basis of the above MTUS Chronic Pain Guidelines and available provider documentation, the request is not medically necessary and appropriate.