

Case Number:	CM13-0038629		
Date Assigned:	12/18/2013	Date of Injury:	10/22/1999
Decision Date:	02/07/2014	UR Denial Date:	09/17/2013
Priority:	Standard	Application Received:	09/30/2013

HOW THE IMR FINAL DETERMINATION WAS MADE

MAXIMUS Federal Services sent the complete case file to a physician reviewer. He/she has no affiliation with the employer, employee, providers or the claims administrator. The physician reviewer is Board Certified in Physical Medicine and Rehabilitation, has a subspecialty in Neuromuscular Medicine 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 physician 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:

46-year-old female who is complaining of low back pain, which is located in the midline of the lower lumbar spine and radiates down the anterior thigh and the posterior aspect of the left lower extremity to the ankle. She was employed as a food service worker at a local hospital. After lifting a table, she began having severe low back pain. She subsequently underwent a lumbar fusion in 2000. She continues to complain of low back pain and left lower extremity pain. Her diagnosis include Status post lumbar fusion at L4 through S1 In 2000 2. Adjacent segment syndrome. 3. L3, L4 facet syndrome. 4. Lumbar radiculopathy.5. Gastric bypass In 2002.6. History of ulcer. Prior injections include: The patient underwent an epidural steroid injection, which provided relief for several months. The patient underwent a caudal epidural steroid injection dated 01/27/2009. The patient underwent a caudal epidural steroid injection dated 11/11/2008 .The patient underwent a transforaminal epidural steroid injection at L3/4 bilaterally performed on 12/06/2006. 10/23/13 physical exam: Neurological: Right: 5/5 all muscle groups. Left: 5/5 all muscle groups. Lower Extremities: Right: 4/5 all muscle groups. Left: 5/5 all muscle groups. General: Alert and oriented x3 Cranial Nerves: 2-12 grossly intact Sensory: Upper Extremities: Right: Normal sensation to light touch. Left: Normal sensation to light touch. Lower Extremities: Right: Reduced sensation to light touch along the lateral right thigh. Left: Normal sensation to light touch. Deep Tendon Reflexes: Upper Extremities: Right: Biceps-- 1/4; Brachioradialis-- 1/4; Triceps-- 1/4 Left: Biceps-- 1/4; Brachioradialis-- 1/4; Triceps-- 1/4 Lower Extremities: Right: Patellar--- 2/4; Achilles--- 1/4 Left: Patellar--- 2/4; Achilles--- 1/4 Provocative Tests: Straight leg-raising test: Positive on the right at 45 degrees with pain radiating to the foot and negative on the left. FABER test: Negative bilaterally. . Primary Treating Physician's Progress Rep

IMR ISSUES, DECISIONS AND RATIONALES

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

lumbar transforaminal epidural steroid injection (ESI) at the left L3-4: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs).

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

Decision rationale: Lumbar transforaminal epidural steroid injection (ESI) at the left L3-4 is not medically necessary per MTUS guidelines. Per guidelines, "Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing." Per documentation submitted patient's most recent imaging studies or last electrodiagnostic testing, do not corroborate her physical exam findings/radiculopathy. Additionally there is no documentation that prior injections have shown at least 50% pain relief or functional improvement for 6-8 weeks. Per guidelines. "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)" Chronic Pain Medical Treatment Guidelines 8 C.C.R. Â§Â§9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page 46 of 127, "Epidural steroid injections (ESIs) Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). See specific criteria for use below. Most current guidelines recommend no more than 2 ESI injections. This is in contradiction to previous generally cited recommendations for a "series of three" ESIs. These early recommendations were primarily based on anecdotal evidence. Research has now shown that, on average, less than two injections are required for a successful ESI outcome. Current recommendations suggest a second epidural injection if partial success is produced with the first injection and a third ESI is rarely recommended. Epidural steroid injection can offer short-term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. There is little information on improved function. The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months, and there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain. (Armon, 2007) See also Epidural steroid injections, "series of three." Criteria for the use of Epidural steroid injections: Note: The purpose of ESI is 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 functional benefit. 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to con

additional transforaminal epidural steroid injection (ESI) at L4-5 and L5-S1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs).

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

Decision rationale: Lumbar transforaminal epidural steroid injection (ESI) at the left L3-4 is not medically necessary per MTUS guidelines. Per guidelines, "Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing." Per documentation submitted patient's most recent imaging studies or last electrodiagnostic testing, do not corroborate her physical exam findings/radiculopathy. Additionally there is no documentation that prior injections have shown at least 50% pain relief or functional improvement for 6-8 weeks. Per guidelines. "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)" Chronic Pain Medical Treatment Guidelines 8 C.C.R. Â§Â§9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page 46 of 127 Epidural steroid injections (ESIs) Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). See specific criteria for use below. Most current guidelines recommend no more than 2 ESI injections. This is in contradiction to previous generally cited recommendations for a "series of three" ESIs. These early recommendations were primarily based on anecdotal evidence. Research has now shown that, on average, less than two injections are required for a successful ESI outcome. Current recommendations suggest a second epidural injection if partial success is produced with the first injection and a third ESI is rarely recommended. Epidural steroid injection can offer short-term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. There is little information on improved function. The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months, and there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain. (Armon, 2007) See also Epidural steroid injections, "series of three." Criteria for the use of Epidural steroid injections: Note: The purpose of ESI is 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 functional benefit. 1) Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 2) Initially unresponsive to cons

fluoroscopy: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections (ESIs).

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

Decision rationale: Fluoroscopy is not medically necessary per MTUS guidelines, as epidural steroid injections are not medically necessary. Per MTUS guidelines. "Injections should be performed using fluoroscopy (live x-ray) for guidance." Injections were deemed not medically necessary therefore, fluoroscopy is not medically necessary. Chronic Pain Medical Treatment Guidelines 8 C.C.R. §§9792.20 - 9792.26 MTUS (Effective July 18, 2009) Page 46 of 127: Epidural steroid injections (ESIs) Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). See specific criteria for use below. Most current guidelines recommend no more than 2 ESI injections. This is in contradiction to previous generally cited recommendations for a "series of three" ESIs. These early recommendations were primarily based on anecdotal evidence. Research has now shown that, on average, less than two injections are required for a successful ESI outcome. Current recommendations suggest a second epidural injection if partial success is produced with the first injection and a third ESI is rarely recommended. Epidural steroid injection can offer short-term pain relief and use should be in conjunction with other rehab efforts, including continuing a home exercise program. There is little information on improved function. The American Academy of Neurology recently concluded that epidural steroid injections may lead to an improvement in radicular lumbosacral pain between 2 and 6 weeks following the injection, but they do not affect impairment of function or the need for surgery and do not provide long-term pain relief beyond 3 months, and there is insufficient evidence to make any recommendation for the use of epidural steroid injections to treat radicular cervical pain. (Armon, 2007) See also Epidural steroid injections, "series of three." Criteria for the use of Epidural steroid injections: Note: The purpose of ESI is 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 functional benefit.

- 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). (Manchikanti, 2003) (CMS, 2004) (Boswe