

| | | | |
|-----------------------|--------------|------------------------------|------------|
| Case Number: | CM14-0014841 | | |
| Date Assigned: | 02/28/2014 | Date of Injury: | 11/06/2013 |
| Decision Date: | 08/22/2014 | UR Denial Date: | 01/20/2014 |
| Priority: | Standard | Application Received: | 02/05/2014 |

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 Physical Medicine and Rehabilitation, has a subspecialty in Pain Management and is licensed to practice in California. 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:

This is a male patient with a date of injury of November 6, 2013. A utilization review determination dated January 17, 2014 recommends non-certification of bilateral S-1 and if needed L5 transforaminal epidural steroid injection via epidurogram and bilateral L 5 - S 1 facet joint injection. A progress note dated January 10, 2014 identifies subjective complaints of lower back pain that is worse with sitting, intermittent neck discomfort, no improvement with physical therapy, and decreased low back pain when lying prone and arches his back. Physical examination of the lumbar spine identifies tenderness at the L5 - S1 level midline at both sides, lumbar extension and flexion are mild to moderately limited, straight leg raising is mildly positive for back pain but not like pain, distal sensation, motor, and reflex testing our normal, tenderness over the sciatic notch, and no SI joint tenderness. Diagnoses include lumbar disc degeneration, lumbosacral radiculitis, and lumbar disc displacement without myelopathy. The treatment plan recommends diagnostic and therapeutic bilateral S-1 and if needed L5 transforaminal epidural injections combined with bilateral L5 - S1 facet joint injections. An MRI of the lumbar spine performed on December 11, 2013 identifies at the L5-S1 level a small diffused disc protrusion slightly eccentric to the right subarticular zone just about touching the right S1 nerve root in the lateral recess, and mild to moderate bilateral posterior facet arthropathy at L4 - L5 and at L5 S1. An appeal note dated January 28, 2014 identifies subjective complaints of low back symptoms on the right side and bilateral leg symptoms. The patient states he cannot stand, sit, or walk for more than five minutes. He has increased symptoms when he bends forward, when he arches his back, after 15 minutes of driving a vehicle, and after exercising too much. The patient states that any activity bothers him, and his buttock and leg symptoms are dramatically worsened within five minutes of sitting, standing, or walking. The patient also reports that bending backward or flexing forward bothers his legs. The requesting physician

states that the patient's legs give out on him when he walks which is an indication of a nerve compression intermittently. He also states that the patient has lumbar stiffness and that he tosses and turns at night trying to get comfortable in order to sleep. The requesting physician also states that the patient may end up pursuing the L5 and S1 epidural injections along with the L5 - S1 facet injections under his private insurance if not approved.

IMR ISSUES, DECISIONS AND RATIONALES

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

BILATERAL S1 AND IF NEEDED L5 TRANSFORMINAL ESI VIA EPIDUROGRAM AND BILATERAL L5-S1 FACET INJECTION: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM.

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs); Low Back Page(s): 46, 300, 309. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Low Back Chapter, Epidural Steroid Injections, diagnostic; Facet Joint Pain, Signs & Symptoms, Facet Joint Diagnostic Blocks (Injections), Facet Joint Medial Branch Blocks (Therapeutic).

Decision rationale: Regarding the request for bilateral S1 and if needed L5 transforaminal ESI via epidurogram and bilateral L5-S1 facet injections, Chronic Pain Medical Treatment Guidelines state that epidural injections are recommended as an option for treatment of radicular pain, defined as pain in dermatomal distribution with corroborative findings of radiculopathy. ODG states when used for diagnostic purposes the following indications have been recommended: 1) To determine the level of radicular pain, in cases where diagnostic imaging is ambiguous, including the examples below: 2) To help to evaluate a radicular pain generator when physical signs and symptoms differ from that found on imaging studies; 3) To help to determine pain generators when there is evidence of multi-level nerve root compression; 4) To help to determine pain generators when clinical findings are consistent with radiculopathy (e.g., dermatomal distribution) but imaging studies are inconclusive; 5) To help to identify the origin of pain in patients who have had previous spinal surgery. Regarding the request for lumbar facet injections, Chronic Pain Medical Treatment Guidelines state that invasive techniques are of questionable merit. ODG guidelines state that facet joint injections may be indicated if there is tenderness to palpation in the paravertebral area, a normal sensory examination, and absence of radicular findings. Within the medical information available for review, there are no objective examination findings supporting a diagnosis of radiculopathy. Furthermore, it is not recommended to perform epidural injections at the same time as facet injections because of possibility of nonspecific and misleading results. Additionally, facet injections are not recommended when radiculopathy is present, which is being stated in this case. As such, the requested bilateral S1 and if needed L5 transforaminal ESI via epidurogram and bilateral L5-S1 facet injections are not medically necessary.