

Case Number:	CM14-0137311		
Date Assigned:	09/05/2014	Date of Injury:	11/16/2011
Decision Date:	10/02/2014	UR Denial Date:	07/25/2014
Priority:	Standard	Application Received:	08/25/2014

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 Family Medicine 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 female patient who reported an industrial injury to the back on 11/16/2011, almost three (3) years ago, attributed to the performance of her usual and customary job tasks. It was noted that an EMG/NCV (Electromyography / Nerve Conduction Velocity) of the bilateral lower extremities dated 11/22/2013, documented evidence of a bilateral S1 radiculopathy. The panel QME (Qualified Medical Examination) diagnoses for the patient included chronic lumbar spine sprain/strain; MRI evidence of two millimeter disc bulge at L4-L5 and L5-S1 with bilateral facet arthropathy resulting in mild bilateral neural foraminal narrowing, lumbar facet syndrome, sciatic neuritis, lumbar radiculopathy right lower extremity, chronic thoracic spine sprain/strain; chronic right knee sprain/strain, right knee neuritis/chondromalacia patella/osteoarthritis, patellar tendinitis, MRI evidence of right knee osteoarthritic changes, chronic right foot and ankle sprain/strain; chronic myofascial is, and right lower extremity neuropathic limb pain. The MRI of the lumbar spine dated 10/30/2013 documented evidence of L3-L4 broad-based central disc protrusion less than 1.0 mm; effaces the thecal sac with encroachment to the bilateral exiting nerve root; L4-L5 broad based disc protrusion 3.2 mm; effaces the thecal sac and bilateral transiting nerve roots with compression to the bilateral exiting nerve roots; facet arthrosis; and disc protrusion results and bilateral neural foraminal stenosis; ligamentum flavum buckling; L5-S1 broad-based central disc protrusion 4.3 mm and encroaches the epidural space; facet arthrosis and disc protrusion results and bilateral neural foraminal stenosis; grade 1 retrolisthesis at L5 1.4 mm. The recent office visit reported that the patient complained of low back pain and right knee pain. The patient was noted to be improving with the 12 authorized sessions of physical therapy. The objective findings on examination included positive SLR on the right, negative on the left and normal reflexes. The treatment plan included additional physical therapy to the right knee

and low back; Celebrex; tramadol; and a lumbar spine TFLESI L5-S1 (Transforaminal L5-S1 Epidural Steroid Injection) with myelogram, fluoro, and conscious sedation.

IMR ISSUES, DECISIONS AND RATIONALES

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

Transforaminal L5-S1 Epidural Steroid Injection with Myelogram, under Fluoroscopy guidance and Conscious Sedation: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural Steroid Injections Page(s): 46.

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300; 179-180, Chronic Pain Treatment Guidelines Epidural Steroid injections Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Section low back chapter lumbar spine ESI

Decision rationale: The criteria required by the CA MTUS for the provision of a lumbar ESI were not documented by the requesting provider. The patient does meet the CA MTUS criteria for a lumbar ESI under fluoroscopic guidance. The use of lumbar spine ESIs is recommended for the treatment of acute or subacute radicular pain in order to avoid surgical intervention. The patient is not noted to have objective findings on examination consistent with a nerve impingement radiculopathy. The reported radiculopathy was not corroborated by imaging studies or Electrodiagnostic studies. There is no impending surgical intervention. The patient is being treated for chronic low back pain attributed to an annular tear and lumbar spine DDD (Degenerative Disc Disease) The patient is documented to of had a rehabilitation effort along with physical therapy; however, the last office visit documented no neurological deficits along a dermatomal distribution to the bilateral lower extremities and noted that the patient was improving with physical therapy and exercise. As noted that there was electrodiagnostic evidence of a bilateral S1 radiculopathy; however, this was not corroborated with the objective findings on examination and the MRI studies. The stated diagnoses and clinical findings do not meet the criteria recommended by evidence-based guidelines for the use of a lumbar ESI by pain management. The CA MTUS requires that "Radiculopathy must be documented by physical examination and corroborated by imaging studies and/or Electrodiagnostic testing." The ACOEM Guidelines updated Back Chapter revised 8/08/08 does not recommend the use of lumbar ESIs for chronic lower back pain. The Official Disability Guidelines recommend that ESIs are utilized only in defined radiculopathies and a maximum of two lumbar diagnostic ESIs and a limited number of therapeutic lumbar ESIs are recommended in order for the patient to take advantage of the window of relief to establish an appropriate self-directed home exercise program for conditioning and strengthening. The criteria for a second diagnostic ESI is that the claimant obtain at least 50% relief from the prior appropriately placed ESI. The therapeutic lumbar ESIs are only recommended, "If the patient obtains 50-70% pain relief for at least 6-8 weeks." Additional blocks may be required; however, the consensus recommendation is for no more than four (4) blocks per region per year. The indications for repeat blocks include "acute exacerbations of pain or new onset of symptoms." Lumbar ESIs should be performed at no more than two levels at a session. Although epidural injection of steroids may afford short-term

improvement in the pain and sensory deficits in patients with radiculopathy due to herniated nucleus pulposus, this treatment, per the guidelines, seems to offer no significant long-term functional benefit, and the number of injections should be limited to two, and only as an option for short term relief of radicular pain after failure of conservative treatment and as a means of avoiding surgery and facilitating return to activity. The patient is being treated for a subjective radiculitis with reported chronic low back without MRI or EMG/NCV (Electromyography / Nerve Conduction Velocity) evidence of a nerve impingement radiculopathy. There is no demonstrated medical necessity for a lumbar spine ESI (Epidural Steroid Injection) for the reported chronic pain issues. The request for a Transforaminal L5-S1 Epidural Steroid Injection with Myelogram, under Fluoroscopy guidance and Conscious Sedation is not medically necessary and appropriate.