

<b>Case Number:</b>	CM14-0053531		
<b>Date Assigned:</b>	07/07/2014	<b>Date of Injury:</b>	02/05/1997
<b>Decision Date:</b>	08/27/2014	<b>UR Denial Date:</b>	04/16/2014
<b>Priority:</b>	Standard	<b>Application Received:</b>	04/22/2014

### 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 General Preventive Medicine and is licensed to practice in Indiana. 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 employee is a 53 year old male with date of injury of 2/5/1997. A review of the medical records indicates that the patient is undergoing treatment for lumbosacral spondylosis without myelopathy. Subjective complaints include back and lower extremity pain with right more than left with tingling and numbness. Objective findings include antalgic gait and tenderness of the right lumbar paravertebral regions at L3, L4, L5, and S1, and positive straight leg raise. Treatment has included norco, suboxone 8mg, discogram, radiofrequency, SI injections. The utilization review dated 4/6/2014 non-certified right L4-5 transforaminal ESI, possible L5-S1 transforaminal ESI, X-ray of lumbosacral 2 or 3 views, and needle localization by X ray.

### IMR ISSUES, DECISIONS AND RATIONALES

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

**Right L4-5 transforaminal ESI:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315, Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Facet joint diagnostic blocks (injections), Epidural

steroid injections (ESIs), therapeutic Other Medical Treatment Guideline or Medical Evidence: MD Guidelines, Facet Joint Injections/Therapeutic Facet Joint Injections.

**Decision rationale:** ACOEM Guidelines state invasive techniques (e.g., local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit. The ODG and MD Guidelines agree that "One diagnostic facet joint injection may be recommended for patients with chronic low back pain that is significantly exacerbated by extension and rotation or associated with lumbar rigidity and not alleviated with other conservative treatments (e.g., NSAIDs, aerobic exercise, other exercise, manipulation) in order to determine whether specific interventions targeting the facet joint are recommended . . . If after the initial block/blocks are given (see Diagnostic Phase above) and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks, additional blocks may be supported." Per the ODG, "Indications for repeat blocks include acute exacerbation of pain, or new onset of radicular symptoms . . . Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response." The treating physician does not document any acute exacerbation of pain, new radicular symptoms, continued objective pain relief, or functional response. As such, the request is not medically necessary.

**Possible L5-S1 transforaminal ESI:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315, Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Facet joint diagnostic blocks (injections), Epidural steroid injections (ESIs), therapeutic Other Medical Treatment Guideline or Medical Evidence: MD Guidelines, Facet Joint Injections/Therapeutic Facet Joint Injections.

**Decision rationale:** ACOEM Guidelines state Invasive techniques (e.g., local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit. The ODG and MD Guidelines agree that "One diagnostic facet joint injection may be recommended for patients with chronic low back pain that is significantly exacerbated by extension and rotation or associated with lumbar rigidity and not alleviated with other conservative treatments (e.g., NSAIDs, aerobic exercise, other exercise, manipulation) in order to determine whether specific interventions targeting the facet joint are recommended . . . If after the initial block/blocks are given (see Diagnostic Phase above) and found to produce pain relief of at least 50-70% pain relief for at least 6-8 weeks, additional blocks may be supported." The treating physician does not document at least 50% pain relief. Per the ODG, "Indications for repeat blocks include acute exacerbation of pain, or new onset of radicular symptoms . . . Repeat injections should be based on continued objective documented pain relief, decreased need for pain medications, and functional response." The treating physician does not document any acute exacerbation of pain, new radicular symptoms, continued objective pain relief, or functional response. As such, the request for right L5-S1 transforaminal ESI is not medically necessary.

**X-ray of the lumbosacral 2 or 3 views:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 45-46.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Radiography (x-rays).

**Decision rationale:** The ACOEM Guidelines and the ODG both agree that Lumbar spine x rays should not be recommended in patients with low back pain in the absence of red flags for serious spinal pathology, even if the pain has persisted for at least six weeks. The medical notes provided did not document (physical exam, objective testing, or subjective complaints) any red flags for serious spinal pathology or other findings suggestive of the pathologies outlined in the ODG. The ODG additionally states that an x-ray may be appropriate when the physician believes it would aid in patient management. The treating physician also does not indicate how the x-ray would aid in patient management. As such, the request for X-ray of the lumbosacral 2 or 3 views is not medically necessary.

**Needle localization by X-ray:** Upheld

**Claims Administrator guideline:** Decision based on MTUS Chronic Pain Treatment Guidelines Page(s): 45-46.

**MAXIMUS guideline:** Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 287-315, Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs) Page(s): 46. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low Back - Lumbar & Thoracic (Acute & Chronic), Facet joint diagnostic blocks (injections), Epidural steroid injections (ESIs), therapeutic Other Medical Treatment Guideline or Medical Evidence: MD Guidelines, Facet Joint Injections/Therapeutic Facet Joint Injections.

**Decision rationale:** Since the primary procedure is not medically necessary, none of the associated services are medically necessary.