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| Case Number: | CM14-0190871 | | |
| Date Assigned: | 11/24/2014 | Date of Injury: | 01/04/2011 |
| Decision Date: | 01/09/2015 | UR Denial Date: | 10/18/2014 |
| Priority: | Standard | Application Received: | 11/17/2014 |

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 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:

The patient is an injured worker with a lumbar spine condition. Date of injury was 01-04-2011. Lumbar spine magnetic resonance imaging dated July 25, 2012 demonstrated disk desiccation without narrowing is seen at L4-L5. No disk bulges or protrusions are identified at L4-L5. Decreased disk height with disk desiccation is noted at L5-S1. No disk bulges or protrusions are identified at L5-S1. Decreased disk height, disk desiccation with Grade I spondylolisthesis noted at the L5-S1 level. This appears to be associated with bilateral L5 spondylolysis and results in moderate to marked cephalocaudad narrowing of the L5 neural foramina bilaterally. Disk desiccation, anterolateral osteophytes with moderate right-sided degenerative facet changes noted at the L4-L5 level. There is associated moderate narrowing of the right L4 neural foramen and mild narrowing of the left L4 neural foramen. Grade I spondylolisthesis is noted at the L5-S1 level. This appears to be associated with bilateral L5 spondylolysis. Moderate right-sided degenerative facet changes are noted at the L4-L5 level. The remainder of the facet joints and posterior elements appear normal. The vertebral bodies are of normal height. The visualized distal spinal cord including the conus medullaris, filum terminale, and cauda equina is within normal limits. No bony stenosis of the spinal canal is identified. There is moderate to marked cephalocaudad narrowing of the L5 neural foramina bilaterally. There is moderate narrowing of the right L4 neural foramen and mild narrowing of the left L4, bilateral L2, and bilateral L3 neural foramina. The orthopedic evaluation report dated August 1, 2014 documented a lumbar spine condition. While at work on January 4, 2011, the patient was pushing a heavy cart when he felt a significant increase in his lower back pain. He had pain radiating into the right lower extremity. He was felt to have a lumbar strain and lower back pain radiating into the right more than left buttock and leg with muscle spasms. He had one lumbar epidural injection in February of 2013. He had a second injection in March of 2013. A third epidural was requested but was

denied. Medical records review was performed. Lumbar epidural selective injection L4-S1 nerve roots was performed on 2/15/13. Right lumbar transforaminal selective nerve root steroid injection right L5-S1 was performed on 2/15/13. The progress report dated 3/8/13 documented that the patient had 50% improvement with epidural injection. Repeat lumbar epidural injection right L5 was recommended. Lumbar epidural selective injection L5-S1 was performed on 3/25/13. Right transforaminal selective nerve root steroid injection right L5-S1 was performed on 3/25/13. The progress report dated 4/5/13 documented that the patient had 50% lasting relief of back and leg pain with epidural. Repeat lumbar epidural transforaminal injection right L5 was requested. Electromyography (EMG) and nerve conduction study (NCS) performed 7/29/13 demonstrated moderate to severe left L5 and S1 lumbosacral radiculopathy. Mild to moderate right S1 lumbar radiculopathy was noted on EMG/NCS. Mild to moderate sensory peripheral neuropathy both lower extremities was noted on EMG/NCS. The pain management consultation report dated 10/9/14 documented subjective complaints of lower back pain with bilateral leg and thigh pain. Physical examination included reversal lordosis, flattened back, low back pain, right lower extremity weakness, positive right straight leg raising, flexion 60 degrees, extension 25 degrees, and altered gait. Diagnoses were L5-S1 spondylolisthesis, lumbar disc herniation, right radiculopathy, sciatica, and lumbosacral sprain and strain. Request for authorization (RFA) dated 10/9/14 requested lumbar transforaminal ESI epidural steroid injection right L5-S1.

IMR ISSUES, DECISIONS AND RATIONALES

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

Transforaminal Epidural Steroid Injection, right L5-S1: 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, Chronic Pain Treatment Guidelines Epidural steroid injections ESIs Page(s): 46.

Decision rationale: Medical Treatment Utilization Schedule (MTUS) addresses epidural steroid injections (ESIs). American College of Occupational and Environmental Medicine (ACOEM) 2nd Edition (2004) Chapter 12 Low Back Complaints (Page 300) states that invasive techniques (e.g., local injections and facet-joint injections of cortisone and lidocaine) are of questionable merit. Epidural steroid injections treatment offers no significant long-term functional benefit, nor does it reduce the need for surgery. Chronic Pain Medical Treatment Guidelines (Page 46) states that epidural steroid injections (ESIs) are recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy). The American Academy of Neurology concluded that epidural steroid injections do not affect impairment of function or the need for surgery and do not provide long-term pain relief. ESI treatment alone offers no significant long-term functional benefit. 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. Most current guidelines recommend no more than 2 ESI injections. Current research does not support a series-of-three injections in either the diagnostic or therapeutic phase. No more than 2 epidural steroid injections are recommended. The orthopedic evaluation report dated August 1, 2014 documented

one lumbar epidural injection in February of 2013 and a second injection in March of 2013. Lumbar epidural selective injection L4-S1 nerve roots was performed on 2/15/13. Right lumbar transforaminal selective nerve root steroid injection right L5-S1 was performed on 2/15/13. Lumbar epidural selective injection L5-S1 was performed on 3/25/13. Right transforaminal selective nerve root steroid injection right L5-S1 was performed on 3/25/13. Request for authorization (RFA) dated 10/9/14 requested a third lumbar transforaminal ESI epidural steroid injection right L5-S1. Per MTUS, most current guidelines recommend no more than 2 ESI injections. Current research does not support a series-of-three injections in either the diagnostic or therapeutic phase. No more than 2 epidural steroid injections are recommended. Therefore, the request for Transforaminal Epidural Steroid Injection, right L5-S1 is not medically necessary.