

Case Number:	CM15-0003487		
Date Assigned:	01/14/2015	Date of Injury:	07/16/2010
Decision Date:	03/12/2015	UR Denial Date:	12/03/2014
Priority:	Standard	Application Received:	01/07/2015

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. 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/Service. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

The Expert Reviewer has the following credentials:
 State(s) of Licensure: District of Columbia, Virginia
 Certification(s)/Specialty: Internal Medicine

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 53 year old female sustained a work related injury on 07/16/2010. According to a progress report dated 11/20/2014, the injured worker complained of lower back pain that was rated a 6 on a scale of 0-10. She denied radicular symptoms into her lower extremities. She also reported recent numbness of her great right toe. Home exercises were being continued with benefit. MRI of the lumbar spine revealed multilevel moderate to severe degenerative disc disease of the lumbar spine, disc protrusion was noted as L2-L3, L3-L4, L4-L5, L5-S1 causing central canal and foraminal stenosis; grade 1 anterior listhesis of L4 on L5. Diagnoses included sciatica, unspecified major depression recurrent episode, stenosis spinal lumbar, lumbar disc displacement without myelopathy, syndrome postlaminectomy lumbar, status post hemilaminectomy L4-L5 around 2000, degeneration lumbar lumbosacral disc and disorders sacrum. On 12/03/2014, Utilization Review non-certified bilateral lumbar facet joint injection L3-L4, L4-L5 each additional level, fluoroscopic guidance intravenous sedation. According to the Utilization Review physician, the request was for 3 levels which exceeds guideline recommendations of no more than 2 levels bilaterally. In regards to intravenous sedation, the guidelines state that it should only be given in cases of extreme anxiety, as it may be grounds to negate the results of a diagnostic block. There was lack of documentation indicating extreme anxiety to warrant the necessity of intravenous sedation. Guidelines cited for this review included California MTUS ACOEM Chapter 12, pages 837-839. The decision was appealed for an Independent Medical Review.

IMR ISSUES, DECISIONS AND RATIONALES

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

Bilateral Lumbar Facet Joint Injection L3-L4, L4-L5 each additional level, fluoroscopic guidance IV sedation: Upheld

Claims Administrator guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints. Decision based on Non-MTUS Citation Official Disability Guidelines

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines 9792, pg 46 Page(s): 46.

Decision rationale: Per MTUS, 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) 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) 8) Current research does not support a series-of-three injections in either the diagnostic or therapeutic phase. We recommend no more than 2 ESI injections. Per guidelines, two level

injections are recommended and there was no indication to go beyond the recommended levels for injections.