

Case Number:	CM15-0102410		
Date Assigned:	06/05/2015	Date of Injury:	01/10/1982
Decision Date:	07/13/2015	UR Denial Date:	05/12/2015
Priority:	Standard	Application Received:	05/28/2015

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: New York
 Certification(s)/Specialty: Anesthesiology

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 injured worker is a 63 year old male, who sustained an industrial injury on 01/10/1982. On provider visit dated 05/06/2015 the injured worker has reported for lower back pain management. On examination of the bilateral C5-T2 and L4-S1 spinous and paraspinous tenderness was noted as well as bilateral sacroiliac joint tenderness. Positive facet load test C5-T2 and L4-S1 facets. Positive Faber's test, positive bilateral piriformis tenderness and multiple myofascial trigger points and joint tenderness were noted. The diagnoses have included chronic low back pain, myofascial pain syndrome, lumbar and cervical spondylosis and inflammatory radiculopathy, bilateral sacroiliac joint arthropathy and bilateral cervical and lumbar facet arthropathy. Treatment to date has included medication and injections. The provider requested L1-L2, L4-L5 translaminar epidural steroid injections with epidurogram, one bilateral L4-S1 facet joint injections, one bilateral sacroiliac joint injection, one bilateral piriformis injection, six low back trigger point injections with steroids, and Ambien 10mg #30.

IMR ISSUES, DECISIONS AND RATIONALES

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

L1-L2, L4-L5 translaminar epidural steroid injections with epidurogram (between 5/11/2015 and 8/9/2015): Upheld

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

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

Decision rationale: Epidural steroid injections (ESIs) are recommended as an option for treatment of radicular pain (defined as pain in a dermatomal distribution with corroborative findings of radiculopathy). Most current guidelines recommend no more than 2 ESI injections. Research has shown that, on average, less than two injections are required for a successful ESI outcome. ESIs can offer short-term pain relief and use should be in conjunction with other rehab efforts. The purpose of ESIs 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. 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. The CA MTUS guidelines state radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electro-diagnostic testing. The patient must be initially unresponsive to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). In this case, the patient has indicated that medications and past physical therapy has improved his symptoms. This patient received a previous lumbar ESI with improvement of low back pain, however, there is no evidence that this resulted in at least 50% pain relief with associated reduction of medications for 6 to 8 weeks. Therefore, medical necessity for the requested L1-L2 and L4-L5 translaminar ESIs with epidurogram has not been established. The requested procedures are not medically necessary.

One (1) bilateral L4-S1 facet joint injections (between 5/11/2015 and 8/9/2015): Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints.

Decision rationale: The CA MTUS reference to ACOEM identifies documentation of non-radicular facet mediated pain, as criteria necessary to support the medical necessity of lumbar facet injections, or medial branch blocks. The ODG identifies, that if successful (pain relief of at least 50% for a duration of at least 6 weeks), the recommendation is to proceed to a medial branch diagnostic block and subsequent neurotomy (if the medial branch block is positive). The facet joint injections are limited to patients with low-back pain that is non-radicular (and at no more than two levels bilaterally). In this case, there is documentation of radiculopathy. Therefore, based on guidelines and a review of the evidence, medical necessity for the requested injections have not been established. The request for bilateral lumbar facet injections at L4-S1 is not medically necessary.

One (1) bilateral sacroiliac joint injection (between 5/11/2015 and 8/9/2015): Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Sacroiliac Joint Blocks.

Decision rationale: Sacroiliac joint injections (SIJ) are recommended as an option if the patient has failed at least 4-6 weeks of aggressive conservative therapy. Sacroiliac dysfunction is poorly defined and the diagnosis is often difficult to make due to the presence of other low back pathology (including spinal stenosis and facet arthropathy). The diagnosis is also difficult to make as pain symptoms may depend on the region of the SI joint that is involved (anterior, posterior, and/or extra-articular ligaments). Pain may radiate into the buttock, groin and entire ipsilateral lower limb, although if pain is present above L5, it is not thought to be from the SI joint. Criteria for the use of SIJ blocks include that the patient has had and failed at least 4-6 weeks of aggressive conservative therapy including, physical therapy (PT), home exercise and medication management. In this case, the patient has indicated that medications and past PT have improved his symptoms. Therefore, medical necessity for the bilateral SIJ injections has not been established. The requested bilateral procedure is not medically necessary.

One (1) bilateral piriformis injection (between 5/11/2015 and 8/9/2015): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Low back pain, Piriformis injections.

Decision rationale: Piriformis injections are recommended for piriformis syndrome after a one-month physical therapy (PT) trial. The piriformis syndrome is a common cause of low back pain and accounts for 6-8% of patients presenting with buttock pain, which may variably be associated with sciatica, due to a compression of the sciatic nerve by the piriformis muscle (behind the hip joint). In this case, the patient has indicated that medications and past PT have been effective at managing his pain. Therefore, medical necessity for the bilateral piriformis injections has not been established. The requested bilateral procedure is not medically necessary.

Six (6) low back trigger point injections (between 5/11/2015 and 8/9/2015): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Trigger point injections Page(s): 122.

Decision rationale: According to California MTUS Guidelines, trigger point injections with a local anesthetic may be recommended for the treatment of chronic low back or neck pain with myofascial pain syndrome when all of the following criteria are met: 1) Documentation of circumscribed trigger points with evidence upon palpation of a twitch response as well as referred pain; 2) Symptoms have persisted for more than three months; 3) Medical management therapies such as ongoing stretching exercises, physical therapy, NSAIDs and muscle relaxants have failed to control pain; 4) Radiculopathy is not present on exam; 5) Not more than 3-4 injections per session; 6) No repeat injections unless greater than 50% pain relief is obtained for six weeks after an injection and there is documented evidence of functional improvement; 7) Frequency should be at an interval less than 2 months; 8) Trigger point injections with any substance other than local anesthetic with or without steroid are not recommended. There was no documentation provided indicating circumscribed trigger points with palpable twitch response and referred pain. Medical necessity for the requested injections has not been established. The requested trigger point injections are not medically necessary.

One (1) bilateral hip injections with steroids (between 5/11/2015 and 8/9/2015): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG).

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Intra-articular steroid hip injection (IASHI), Trochanteric bursitis injections.

Decision rationale: According to the ODG, intra-articular steroid hip injections (IASHI) are not recommended in early hip osteoarthritis (OA). IASHI are under study for moderately advanced or severe hip OA, but if used, should be in conjunction with fluoroscopic guidance. Hip/bursa injections are recommended as an option for short-term pain relief in hip trochanteric bursitis. For trochanteric pain, corticosteroid injection is safe and highly effective, with a single corticosteroid injection often providing satisfactory pain relief (level of evidence, C). Trochanteric bursitis is the second leading cause of hip pain in adults, and a steroid-anesthetic single injection can provide rapid and prolonged relief, with a 2.7-fold increase in the number of patients who were pain-free at 5 years after a single injection. Steroid injection should be offered as a first-line treatment of trochanteric bursitis, particularly in older adults. Trochanteric corticosteroid injection is a simple, safe procedure that can be diagnostic as well as therapeutic. The use of a combined corticosteroid-anesthetic injection typically results in rapid, long-lasting improvement in pain and in disability. Particularly in older adults, corticosteroid injection should be considered as first-line treatment of trochanteric bursitis because it is safe, simple, and effective. In this case, there is no evidence that the patient has had moderate or severe hip osteoarthritis or trochanteric bursitis. Medical necessity for the requested bilateral hip injections with steroids has not been established. The requested injections are not medically necessary.

Ambien 10 mg #30 (between 5/6/2015 and 8/9/2015): Upheld

Claims Administrator guideline: The Claims Administrator did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Zolpidem Section.

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Insomnia treatment.

Decision rationale: Ambien (Zolpidem) is a prescription short-acting non-benzodiazepine hypnotic, which is approved for the short-term treatment of insomnia (usually two to six weeks) and is rarely recommended for long-term use. It can be habit-forming, and may impair function and memory more than opioid analgesics, and may increase pain and depression over the long-term. The treatment of insomnia should be based on the etiology and pharmacological agents should only be used after careful evaluation of potential causes of sleep disturbance. In this case, there was documentation of sleep-walking with Ambien and the patient requested a different medication. Therefore, medical necessity for Ambien has not been established. The requested medication is not medically necessary.