

Case Number:	CM15-0149317		
Date Assigned:	08/12/2015	Date of Injury:	06/16/1988
Decision Date:	09/15/2015	UR Denial Date:	07/10/2015
Priority:	Standard	Application Received:	07/31/2015

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: California, District of Columbia, Maryland
 Certification(s)/Specialty: Anesthesiology, Pain Management

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 53-year-old male, who sustained an industrial injury on 6-16-1988. The mechanism of injury was not noted. The injured worker was diagnosed as having lumbar post-laminectomy syndrome and peripheral neuritis. Treatment to date has included diagnostics, L5-S1 laminectomy, acupuncture, chiropractic, physical therapy, spinal cord stimulator trial, bilateral S1 transforaminal epidural steroid injection (TFESI) and Toradol injection on 12-23-2014, and medications. Currently, the injured worker complains of unchanged pain since his last visit. Pain in his low back was rated 7 out of 10 and burning in his feet was rated 9 out of 10. His left leg pain was rated 2 out of 10. His pain was rated 10 out of 10 without medication use. He was currently working 25-30 hours per week but reported difficulty due to pain while sitting. He reported difficulty with sleep. Medication use included Norco, Lyrica, and Ziac. It was documented that the patient stated he did not have much benefit from the procedure because this was done at the wrong level. The procedure was previously referenced as a bilateral S1 TFESI. The treatment plan included nerve root block (NRB)-TFESI-lumbar bilateral S1.

IMR ISSUES, DECISIONS AND RATIONALES

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

1 lumbar nerve root block (NRB): Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation ODG, Low Back, Epidural Steroid Injections, diagnostic.

Decision rationale: Recommended in selected cases as indicated below. Diagnostic epidural steroid transforaminal injections are also referred to as selective nerve root blocks, and they were originally developed, in part, as a diagnostic technique to determine the level of radicular pain. The role of these blocks has narrowed with the advent of MRIs. Few studies are available to evaluate diagnostic accuracy or post-surgery outcome based on the procedure and there is no gold standard for diagnosis. No more than 2 levels of blocks should be performed on one day. The response to the local anesthetic is considered an important finding in determining nerve root pathology. (CMS, 2004) (Benzon, 2005) When used as a diagnostic technique a small volume of local is used (<1.0 ml) as greater volumes of injectate may spread to adjacent levels. (Sasso, 2005) (Datta, 2013) (Beynon, 2013) Indications for diagnostic epidural steroid injections: 1) To determine the level of radicular pain, in cases where diagnostic imaging is ambiguous, including the examples below: 2) To help to evaluate a radicular pain generator when physical signs and symptoms differ from that found on imaging studies; 3) To help to determine pain generators when there is evidence of multi-level nerve root compression; 4) To help to determine pain generators when clinical findings are consistent with radiculopathy (e.g., dermatomal distribution) but imaging studies are inconclusive; 5) To help to identify the origin of pain in patients who have had previous spinal surgery. Per the documentation submitted for review, MRI dated 3/13/14 revealed at L4-L5 very mild central stenosis and mild bilateral foraminal narrowing. At L5-S1, nerve root canal narrowing was moderate and concentric bilaterally except for the proximal aspect of the left nerve root canal, which was a little more focally stenotic due to facet capsular thickening. EMG/NCV dated 4/30/15 revealed electrodiagnostic evidence of moderate mainly sensory polyneuropathy with predominately-axonal features at the bilateral lower extremities. There was no electrodiagnostic evidence of bilateral lumbosacral radiculopathy. Clinical correlation was recommended. Progress noted dated 3/18/14 noted profound weakness at the right L5 myotome. As the request does not specify a level for the procedure, medical necessity is not medically necessary.

TFESI of lumbar left S1 and right S1: Upheld

Claims Administrator guideline: Decision based on MTUS Chronic Pain Treatment Guidelines Epidural steroid injections (ESIs).

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

Decision rationale: Per the MTUS CPMTG epidural steroid injections are used 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 benefit. The criteria for the use of epidural steroid injections are as follows: 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 the documentation submitted for review, MRI dated 3/13/14 revealed at L4-L5 very mild central stenosis and mild bilateral foraminal narrowing. At L5-S1, nerve root canal narrowing was moderate and concentric bilaterally except for the proximal aspect of the left nerve root canal, which was a little more focally stenotic due to facet capsular thickening. EMG/NCV dated 4/30/15 revealed electrodiagnostic evidence of moderate mainly sensory polyneuropathy with predominately-axonal features at the bilateral lower extremities. There was no electrodiagnostic evidence of bilateral lumbosacral radiculopathy. Clinical correlation was recommended. Progress noted dated 3/18/14 noted profound weakness at the right L5 myotome. Above-mentioned citation conveys radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. Radiculopathy is defined as two of the following: weakness, sensation deficit, or diminished/absent reflexes associated with the relevant dermatome. These findings are not documented. It was noted that on 3/21/15 the injured worker received an epidural steroid injection, which was tolerated well, however, no documentation was provided with regard to pain relief and functional improvement. Per note dated 11/11/14, it was stated that a previous S1 transforaminal epidural steroid injection provided significant pain relief but only for 3 weeks. The request is not medically necessary.