

Case Number:	CM15-0162711		
Date Assigned:	08/31/2015	Date of Injury:	06/19/2014
Decision Date:	10/05/2015	UR Denial Date:	08/06/2015
Priority:	Standard	Application Received:	08/19/2015

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 was a 38-year-old male, who sustained an industrial injury, June 19, 2014. The injured worker previously received the following treatments lumbar spine x-rays with flexion extension views, fusion of L3-L5 with moderate disc degeneration L2-L5 and S1, Percocet and Flexeril, lumbar spine MRI and L2-L3 epidural steroid injection on June 16, 2015. The injured worker was diagnosed with lumbar spondylosis, lumbosacral or thoracic radiculopathy and status post fusion of L3-L5. According to progress note of June 12, 2015, the injured worker's chief complaint was intermittent flare-ups of lower back pain, which radiated to the right hip. The injured worker continued to have intermittent numbness in the feet, which was improving. The injured worker was taking Percocet and Flexeril was filled after several week of giving the injured worker the prescription. The physical exam noted mild discomfort. There was mild pain upon palpation of the lumbar spine. The injured worker had normal strength in the bilateral lower extremities. The injured worker ambulated well with mild discomfort. The treatment plan included right L5-S1 selective nerve root blocks, staged, and separated by two weeks and bilateral S1 joint injections two weeks after the selective nerve root blocks.

IMR ISSUES, DECISIONS AND RATIONALES

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

Right L5 and S1 Selective Nerve Root Blocks, Staged, Separated by 2 Weeks: Upheld

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

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, 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. MRI of the lumbar spine revealed at L4-L5 solid interbody fusion, paired L5 pedicular screws in good position, no neural impinging lesion. At L5-S1 disc height and configuration is normal; facets are only mildly hypertrophic; no evidence of foraminal or central canal bony stenosis and no neural impinging lesion. As the criteria were not met, the request is not medically necessary.

Bilateral SI Joint Injections 2 Weeks After The Selective Nerve Root Blocks: Upheld

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

MAXIMUS guideline: The Expert Reviewer did not base their decision on the MTUS. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG) Hip & Pelvis, and sacroiliac joint blocks.

Decision rationale: The MTUS is silent on the use of sacroiliac joint injections. Per ODG TWC with regard to sacroiliac joint injections: " Recommended as an option if failed at least 4-6 weeks of aggressive conservative therapy as indicated below." Criteria for the use of sacroiliac blocks: 1. The history and physical should suggest the diagnosis (with documentation of at least 3 positive exam findings as listed above). 2. Diagnostic evaluation must first address any other possible pain generators. 3. The patient has had and failed at least 4-6 weeks of aggressive conservative therapy including PT, home exercise and medication management. 4. Blocks are

performed under fluoroscopy. (Hansen, 2003) 5. A positive diagnostic response is recorded as 80% for the duration of the local anesthetic. If the first block is not positive, a second diagnostic block is not performed. 6. If steroids are injected during the initial injection, the duration of pain relief should be at least 6 weeks with at least > 70% pain relief recorded for this period. 7. In the treatment or therapeutic phase (after the stabilization is completed), the suggested frequency for repeat blocks is 2 months or longer between each injection, provided that at least >70% pain relief is obtained for 6 weeks. 8. The block is not to be performed on the same day as a lumbar epidural steroid injection (ESI), transforaminal ESI, facet joint injection or medial branch block. 9. In the treatment or therapeutic phase, the interventional procedures should be repeated only as necessary judging by the medical necessity criteria, and these should be limited to a maximum of 4 times for local anesthetic and steroid blocks over a period of 1 year. The documentation submitted for review did not contain 3 positive exam findings (Cranial Shear Test; Extension Test; Flamingo Test; Fortin Finger Test; Gaenslen's Test; Gillet's Test (One Legged-Stork Test); Patrick's Test (FABER); Pelvic Compression Test; Pelvic Distraction Test; Pelvic Rock Test; Resisted Abduction Test (REAB); Sacroiliac Shear Test; Standing Flexion Test; Seated Flexion Test; Thigh Thrust Test (POSH)) suggesting the diagnosis of SI joint dysfunction. As the criteria were not met, the request is not medically necessary.