

<b>Case Number:</b>	CM15-0225324		
<b>Date Assigned:</b>	11/24/2015	<b>Date of Injury:</b>	11/15/2008
<b>Decision Date:</b>	12/31/2015	<b>UR Denial Date:</b>	10/16/2015
<b>Priority:</b>	Standard	<b>Application Received:</b>	11/17/2015

### 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, Oregon, Washington  
Certification(s)/Specialty: Orthopedic Surgery

### 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 55 [REDACTED] year old female, who sustained an industrial injury on 11-15-2008. The injured worker is being treated for sprain of unspecified parts, intervertebral disc disorder, and sprain of ligaments of lumbar spine. Treatment to date has included medications, psychotherapy, work restrictions and diagnostics. Per the Primary Treating Physician's Progress Report dated 10-06-2015, the injured worker presented for follow-up of thoracic, lumbar and trapezius strain. She reported no new complaints and continued use of Voltaren gel with benefit. Objective findings included tenderness to palpation of the mid dorsal and lumbar spine. There was bilateral sacroiliac joint tenderness. Per the medical records dated 8-25-2015, she reported for severe low back pain with radiation towards both lower extremities, more left than right. Objective findings document "signs of lower extremity radiculopathy" but no specifics are recorded. Magnetic resonance imaging (MRI) of the lumbar spine dated 9-15-2009 was read by the provider as L5-S1 3.5mm herniated nucleus pulposus (HNP), EMG (electromyography)-NCV (nerve conduction studies) (lowers) dated 9-23-2009 were reported as " normal" and MRI of the lumbar spine dated 1-12-2015 showed "4mm HNP at L5-S1." On 10-06-2015, work status was "remain off work until 11-06-2015." The plan of care included lumbar bracing and present medications. On 10-16-2015, Utilization Review non-certified a request for lumbar (L5-S1) transforaminal epidural steroid injection under fluoroscopy and medical clearance (labs CMP, PT, PTT).

### IMR ISSUES, DECISIONS AND RATIONALES

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

## **Lumbar epidural steroid injection transforaminal L5-S1 under fluoroscopy: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**MAXIMUS guideline:** Decision based on MTUS Chronic Pain Medical Treatment 2009, Section(s): Epidural steroid injections (ESIs).

**Decision rationale:** According to the CA MTUS Chronic Pain Medical Treatment Guidelines, Epidural injections, page 46, "Recommended as an option for treatment of radicular pain (defined as pain in dermatomal distribution with corroborative findings of radiculopathy)." Specifically the guidelines state that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. 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. 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. In addition, there must be demonstration of unresponsiveness to conservative treatment (exercises, physical methods, NSAIDs and muscle relaxants). CA MTUS criteria for epidural steroid injections are: "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. In this case the exam notes from 10/6/15 do not demonstrate a failure of conservative management nor a clear evidence of a dermatomal distribution of radiculopathy. Therefore, the proposed epidural steroid injection is not medically necessary and the determination is for non-certification.

## **Medical clearance labs CMP Complete Metabolic Panel: Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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 / Pre-op lab testing.

**Decision rationale:** The CA MTUS/ACOEM Guidelines are silent on the issue of preoperative lab testing. The ODG-TWC low back section was therefore referenced. Pre-op lab testing is recommended as indicated below. Preoperative additional tests are excessively ordered, even for young patients with low surgical risk, with little or no interference in perioperative management. Laboratory tests, besides generating high and unnecessary costs, are not good standardized screening instruments for diseases. The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings. Preoperative routine tests are appropriate if patients with abnormal tests will have a preoperative modified approach (i.e., new tests ordered, referral to a specialist or surgery postponement). Testing should generally be done to confirm a clinical impression, and tests should affect the course of treatment. Criteria for Preoperative lab testing: Preoperative urinalysis is recommended for patients undergoing invasive urologic procedures and those undergoing implantation of foreign material. Electrolyte and creatinine testing should be performed in patients with underlying chronic disease and those taking medications that predispose them to electrolyte abnormalities or renal failure. Random glucose testing should be performed in patients at high risk of undiagnosed diabetes mellitus. In patients with diagnosed diabetes, A1C testing is recommended only if the result would change perioperative management. A complete blood count is indicated for patients with diseases that increase the risk of anemia or patients in whom significant perioperative blood loss is anticipated. Coagulation studies are reserved for patients with a history of bleeding or medical conditions that predispose them to bleeding, and for those taking anticoagulants. In this case, there is no evidence of underlying diseases that predispose to electrolyte abnormalities or renal failure, a high risk of undiagnosed diabetes mellitus, anticipated significant perioperative blood loss, medical conditions that predispose them to bleeding, or anticoagulant use. Thus, this patient does not meet ODG guidelines for the proposed preoperative labs. Therefore, the request is not medically necessary.

## **Medical clearance-Labs PT (Prothrombin Time) and PTT (Partial Thromboplastin Time): Upheld**

**Claims Administrator guideline:** The Claims Administrator did not cite any medical evidence for its decision.

**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 / Pre-op lab testing.

**Decision rationale:** The CA MTUS/ACOEM Guidelines are silent on the issue of preoperative lab testing. The ODG-TWC low back section was therefore referenced. Pre-op lab testing is recommended as indicated below. Preoperative additional tests are excessively ordered, even for young patients with low surgical risk, with little or no interference in perioperative management. Laboratory tests, besides generating high and unnecessary costs, are not good standardized screening instruments for diseases. The decision to order preoperative tests should be guided by the patient's clinical history, comorbidities, and physical examination findings. Preoperative routine tests are appropriate if patients with abnormal tests will have a preoperative modified approach (i.e., new tests ordered, referral to a specialist or surgery postponement). Testing should generally be done to confirm a clinical impression, and tests should affect the course of treatment. Criteria for Preoperative lab testing: Preoperative urinalysis is recommended for patients undergoing invasive urologic procedures and those undergoing implantation of foreign material. Electrolyte and creatinine testing should be performed in patients with underlying chronic disease and those taking medications that predispose them to electrolyte abnormalities or renal failure. Random glucose testing should be performed in patients at high risk of undiagnosed diabetes mellitus. In patients with diagnosed diabetes, A1C testing is recommended only if the result would change perioperative management. A complete blood count is indicated for patients with diseases that increase the risk of anemia or patients in whom significant perioperative blood loss is anticipated. Coagulation studies are reserved for patients with a history of bleeding or medical conditions that predispose them to bleeding, and for those taking anticoagulants. In this case, there is no evidence of underlying diseases that predispose to electrolyte abnormalities or renal failure, a high risk of undiagnosed diabetes mellitus, anticipated significant perioperative blood loss, medical conditions that predispose them to bleeding, or anticoagulant use. Thus, this patient does not meet ODG guidelines for the proposed preoperative labs. Therefore, the request is not medically necessary.