

Case Number:	CM13-0059077		
Date Assigned:	12/30/2013	Date of Injury:	08/02/2010
Decision Date:	01/27/2015	UR Denial Date:	11/06/2013
Priority:	Standard	Application Received:	11/29/2013

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. The expert reviewer is Board Certified in Physical Medicine Rehab, has a subspecialty in Neuromuscular Medicine and is licensed to practice in Maryland. 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/services. He/she is familiar with governing laws and regulations, including the strength of evidence hierarchy that applies to Independent Medical Review determinations.

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 patient is a 43 year old male who had a work injury dated 8/2/10. The diagnoses include degenerative disc disease and moderate spinal stenosis at L5. Under consideration are requests for epidural steroid injection at right L4-L5 for the lumbar spine and right-sided facet blocks for the lumbar spine. A 7/2/11 lumbar MRI revealed that at the L3-4 level there is increased posterior epidural fat. The thecal sac is narrowed in AP dimension to 7 mm. There is a 4 mm broad leftward bulge or protrusion with mild to moderate left neural foraminal encroachment. The posterior elements are unremarkable. At the L4-5 level there is increased epidural fat as well with the thecal sac diminished in AP dimension to 7 mm. There is a 4 mm broad posterior bulge or protrusion indenting the thecal sac with moderate central canal stenosis. At the L5-S1 level the thecal sac is somewhat small due to increased epidural fat measuring 8 mm in dimension. There is a 3-4 mm broad right foraminal bulge or protrusion abutting the exiting right L5 nerve in the mildly stenotic neural foramen. The posterior elements are unremarkable. His treatment has included physical therapy, modified work, lumbar epidural injection, medication management, trigger point injections in the low back. A 09/27/11 dated procedure report for right side L4 and right S1 transforaminal lumbosacral epidural injections. A report from noted that the lumbar epidural injection that had been recommended and was scheduled and performed on July 2, 2011. A 10/30/12 agreed medical evaluation recommended future medical treatment to include 2 sets of lumbar medial branch blocks at L4-5 and L5-S1 followed by a lumbar radiofrequency procedure if the patient had 50% temporary relief of the low back pain with medial branch blocks. A 9/6/13 report reveals that the patient has lower back pain, upper back, neck pain, right lower extremity pain. Numbness 10 out of 10, made worse with activity. The physical examination of the back shows mild right-sided lumbar tenderness. Patient has mild palpable muscle spasm. He has no sacroiliac joint tenderness. Patient's straight-leg-raise test is negative

on the left and positive on the right producing not only right lumbar pain, but pain in the right thigh and buttocks area. Lower extremity strength examination shows 5/5 lower extremity strength in all muscle groups with the exception of the right hip flexors which were 4/5. Next is the sensory examination which was remarkable for numbness on the lateral side of the leg and foot within the vicinity of the S1 nerve root distribution. The treatment plan includes a right transforaminal epidural injection at L4-5.

IMR ISSUES, DECISIONS AND RATIONALES

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

Epidural steroid injection at right L4-L5 for the lumbar spine: 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 (ESIs) Page(s): 46.

Decision rationale: Epidural steroid injection at right L4-L5 for the lumbar spine is not medically necessary per the MTUS Chronic Pain Medical Treatment Guidelines. The guidelines state that radiculopathy must be documented by physical examination and corroborated by imaging studies and/or electrodiagnostic testing. The guidelines state that 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. The most recent physical exam findings are suggestive of a right S1 radiculopathy over an L4-5 radiculopathy. Furthermore the documentation is not clear on the efficacy of the patient's prior epidural steroid injection and whether the patient had 50% pain relief with an associated medication reduction for 6-8 weeks. For these reasons an epidural steroid injection at the right L4-5 is not medically necessary.

Right-sided facet blocks for the lumbar spine: Upheld

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

MAXIMUS guideline: Decision based on MTUS ACOEM Chapter 12 Low Back Complaints Page(s): 300-301. Decision based on Non-MTUS Citation Official Disability Guidelines (ODG), Lumbar & Thoracic (Acute & Chronic)- Facet joint diagnostic blocks (injections)

Decision rationale: Right-sided facet blocks for the lumbar spine are not medically necessary per the MTUS Chronic Pain and the ODG guidelines. The MTUS ACOEM guidelines state that facet neurotomies should be performed only after appropriate investigation involving controlled differential dorsal ramus medial branch diagnostic blocks. The ODG states that medial branch blocks should be limited to patients with low-back pain that is non-radicular and no more than 2 levels. The request as written does not indicate how many levels or the location of the medial

branch block. The physical exam findings are radicular in nature .For these reasons the request for a right sided facet block for the lumbar spine are not medically necessary.